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MICHIGAN'S PHYSICIAN PRIMARY SPONSOR PLAN: IMPLEMENTING PRIMARY CARE CASE MANAGEMENT IN MEDICAID, VOLUME I

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PREFACE

The Medicaid program, which finances health care for over 20 million needy Americans, has undergone major changes since 1981. Beginning with the Omnibus Budget Reconciliation Act of 1981 (OBRA), Congress gave the states much more flexibility to change basic parameters of the program, including which groups of people are served, what services are provided, how doctors, hospitals, and nursing homes are paid, and how care can be organized in innovative ways.

The Medicaid Program Evaluation addresses the implementation and impact of selected changes in the Medicaid program to provide knowledge for policy assessment and future legislative change. It is focused on selected issues and policy questions raised by recent legislation:

- Federal Financial Participation
- Inpatient Hospital Reimbursement
- Eligibility
- Case Management
- Home and Community-Based Waiver Program
- Cost-Sharing
- Financial Incentives for Family Care
- Medicare DRG Effects on Medicaid and
- Synthesis.

Together these studies are intended to describe how recent changes have been implemented, and analyze what their effects have been for program services and costs.

This paper provides a detailed description of the Michigan Primary Physician Sponsor Plan (PPSP), one of the first and largest Medicaid case management programs initiated under OBRA-authorized waivers of the freedom-of-choice requirement. It covers the PPSP's first three years of planning and implementation, including details about the program's design, involvement of providers and recipients, administration, and early impact on the accessibility, quality and costs of care under Medicaid.

The paper is divided into two Volumes. Volume I contains the full text of the report and Volume II contains eleven attachments, which include copies of documents and materials referenced in Volume I.

There are several other MPE Working Papers dealing with the subject of primary care case management. Working Paper 4.1 is a survey of all state activity -- in case management and other areas -- in response to OBRA's relaxation of the Medicaid freedom-of-choice requirement. Working Paper 4.3 provides a detailed case-study of Utah's Choice of Health Care Delivery Program, and 4.4 contains briefer case studies of initiatives in four other states, Kansas, Colorado, Nevada and Wisconsin. Working Paper 4.5 provides a synthesis of findings from all the Task 4 case studies, and 4.6 contains the results of a limited statistical analysis of Utah Medicaid claims data to assess case management's impact on utilization and expenditures.

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While many other Michiganers contributed, we are especially thankful to Sherry Wellman, representing the Michigan State Medical Society and Bill Fairgrieve and Judy Daltuva of the Michigan League for Human Services. Similarly, we are grateful to our colleagues in the Medicaid Program Evaluation for their advice, particularly Gerry Adler, from HCFA's Office of Research and Demonstrations, and Ed Neuschler, the National Governors' Association. We were fortunate to have the participation of Michael Hendricks, who provided useful advice and helped to organize the materials in the report. Finally, Mallory Garner and Rowena Gear skillfully typed the manuscript.

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ACRONYMS USED IN THIS REPORT

CAP	Capitated Ambulatory Plan
FFS	Fee-for-service
HMO	Health Maintenance Organization
MAOPS	Michigan Association of Osteopathic Physicians and Surgeons
MDSS	Michigan Department of Social Services
MLHS	Michigan League for Human Services
MSA	Medical Services Administration
MSMS	Michigan State Medical Society
OBRA	Omnibus Budget Reconciliation Act of 1981
PCCM	Primary Care Case Management
PPSP	Physician Primary Sponsor Plan
TRO	Temporary Restraining Order
WCMS	Wayne County Medical Society

EXECUTIVE SUMMARY

This case study examined the development, implementation and initial operations and effects of Michigan's Physician Primary Sponsor Plan (PPSP). The PPSP is one of the first and largest of the primary care case management programs started under waiver of Medicaid's provisions ensuring recipients unrestricted freedom of choice of provider. Included in the case study are reports on the results of several PPSP studies conducted locally, including a large scale analysis of utilization and expenditures, surveys of PPSP enrollees and Wayne county physicians, and monthly monitoring data compiled by Medicaid and the Michigan League for Human Services.

BACKGROUND

In early 1981, in response to rising Medicaid expenditures and the effects of recession on state revenues, the Michigan Legislature mandated the development of a new, more cost-effective approach to delivering--and reimbursing providers for--Medicaid primary care services. Under this mandate, a task force from the Michigan State Medical Society (MSMS) and the Michigan Association of Osteopathic Physicians and Surgeons (MAOPS) proposed the PPSP. Under the PPSP, Medicaid recipients would be required to enroll with a single primary care physician. This provider would be responsible for delivering or authorizing most of that recipient's medical care on a continuing basis. In return for his or her services as a primary care case manager, the physician would receive a monthly case management fee in addition to the usual fee-for-service (FFS) reimbursement. Instead of placing physicians at risk financially, this model relies on the ability of case management physicians to control inappropriate or duplicative services. It is an attractive model for Medicaid physicians, particularly those in states with very low Medicaid reimbursement rates.

The Michigan Legislature approved the task force's general proposal in October, 1981, and targeted implementation for January, 1982. (This date was later changed to July, 1982, because of the need for more planning time and several disagreements over program provisions.) Being an experimental program,

the PPSP would be implemented initially in only one county, but one which could potentially yield considerable savings to Medicaid. Wayne County (the Detroit area), which has the largest concentration of Medicaid recipients in the state, was chosen. Upon legislative approval, a steering committee, composed of representatives of the MSMS, the MAOPS, and the Medical Services Administration of the Michigan Department of Social Services (MSA/MDSS), was established to develop and implement the PPSP.

At about the same time that the PPSP was being conceived, Congress passed the Omnibus Budget Reconciliation Act of 1981. Section 2175 of the Act created a new section of the Social Security Act (1915 b), which made it possible for the states to obtain freedom-of-choice waivers in order to implement primary care case management programs. Because the PPSP called for a single case managing physician for each enrollee, a restriction of freedom of choice, the MSA/MDSS applied to the U.S. Department of Health and Human Services for the necessary waivers in November, 1981, and received approval shortly after. Additional freedom-of-choice waivers were granted to enable the implementation of two companion programs, a six-month HMO lock-in and the CAP, a capitated ambulatory clinic program, which, with the PPSP and the existing HMO contracts, would provide enrollees with three different options for managed care. Since PPSP operated in one county, a waiver was also needed because of the Medicaid provision requiring that the program be operated the same way throughout the state. The waivers were good for two years, after which renewal was possible.

The steering committee spent the next several months planning the PPSP program in detail, including a contract document that spelled out the respective requirements of participating primary care physicians sponsors and the MSA/MDSS. Briefly, the PPSP design included the following features:

Most Medicaid recipients in Wayne County would be "required" to enroll in the PPSP (or HMO or CAP). (As it turned out, many did not enroll and were still able to obtain services through the regular fee-for-service program.) Not included in case management would be institutionalized long-term care recipients, Medicare-Medicaid dual eligibles, and crippled children.

Any physician would be able to enroll as a case manager, but emphasis would be placed on the primary care specialties--general practice, family practice, internal medicine, obstetrics and gynecology, pediatrics, and general surgery. PPSP enrollees could have case

managers who were non-primary specialists, for example, cardiologists. Typically this would be done in order to continue specialized care that had already begun.

As case managers, physician sponsors would have to render at least 50 percent of their enrollees' care, prior authorize most non-emergency care not provided by them (specialist, X-ray, laboratory, inpatient and outpatient care), and provide recipients with 24-hour access to care.

Enrollees would have to obtain all care from or through their physician sponsors, except in true emergency situations.

Sponsors would receive a case management fee of $3.00 per month for every PPSP enrollee in their caseload. Total monthly case management fees could not exceed $3000 per month, even though a sponsor could case manage up to 1500 enrollees.

After adjustments for caseload type and size, sponsors would have to fall within the 95th percentile of average cost per recipient for major services provided by them or through referrals to specialists. If they exceeded the 95th percentile, they would be subject to sanctions, including withholding of case management fees and termination from the PPSP.

MSA/MDSS would provide sponsor physicians a monthly list of their PPSP enrollees and, when appropriate, utilization and cost reports for enrollees with unusual patterns.

Medicaid recipients would enroll in PPSP (or the HMO or CAP options) on their own in response to brochures and bulletins. PPSP staff, later called Sponsor Specialists, would operate a hotline to facilitate recipient and physician enrollment as well as provide information and deal with problems as they arose. Physicians would enroll by signing the PPSP contract with MDSS. Eventually recipients could enroll through their public assistance caseworkers or their Medicaid physicians.

PPSP enrollees would have the right to change providers or enroll in another of the case management options, for good reason.

This PPSP design was expected to accomplish four major objectives, but the primary aim was to contain costs while paying equitable fees to physicians. It was estimated that if all 286,448 targeted non-institutionalized Medicaid recipients in Wayne County could be enrolled in the program, Medicaid would experience net savings of about $19.7 million per year, about $69 per recipient year. These savings would come primarily from reduced utilization of inpatient, outpatient, physician, emergency room, prescription and laboratory services. At the same time, physicians would receive an estimated $10.3 million in case management fees.

The second PPSP objective was to improve recipients' access to mainstream medical care. This was expected to occur through the enrollment of each recipient under a single primary care physician, and prior authorization of all care. This objective was to be supported by the third PPSP objective, which was to increase overall physician participation in Medicaid. It was expected that such advantages as the case management fee and the ability to exercise some control over the care of Medicaid's traditionally hard-to-manage patients would attract new Medicaid physicians.

The fourth PPSP objective was to improve the management of care for Medicaid recipients which was, of course, highly related to achieving the savings ojective. In effect, this meant reductions in the percentage of recipients who greatly exceeded normal utilization patterns and in the percentage of physicians whose average cost per recipient was excessive.

PROGRESS TO DATE

Physician Participation

We estimated that, before PPSP, fewer than 60 percent of the Wayne County primary care physicians participated in the Medicaid program. A survey of physicians showed that many had negative views of Medicaid patients (uncooperative, prone to inappropriate service utilization, etc.) or the Medicaid program (inadequate reimbursement levels, too much paperwork, etc.). To the extent that the PPSP addressed several of these concerns, Wayne County physicians were expected to respond positively to the new program. Based on the survey, they were expected to like the provisions for patient assignment to one physician, prior authorization of services, and payment of a case management fee. Perhaps the strongest incentive for physicians already in Medicaid to join the PPSP, however, was the desire to maintain their current caseloads.

Three methods were used to market the new program to primary care physicians: articles in professional publications and medical society communications, presentations at professional meetings, and, later on, letters aimed at physicians whom enrollees had specifically identified as their preferred sponsors. While all three methods succeeded in attracting physicians

to PPSP, the largest percentage joined early in response to general PPSP marketing.

By late 1984, PPSP sponsor contracts had been signed by about 37 percent of an estimated 3,100 primary care physicians and about 5 percent of an estimated 2,211 non-primary specialists who had been serving Medicaid recipients before PPSP. It was not possible to determine how successful PPSP was in attracting new physicians to the Medicaid program, but there has not been a problem of too few available sponsor physicians to serve the number of PPSP enrollees. As the number of PPSP enrollees grows, the number of PPSP physicians is likely to grow, too, as some physicians join to retain their Medicaid patients.

Recipient Participation

During the first 21 months of PPSP implementation, MDSS took a hard-line approach to mandatory enrollment. Recipients were initially sent a brochure and letter, instructing them to select either PPSP (and identify a sponsor physician of their choosing) or one of the other managed care options within two weeks. Many recipients responded as expected, but many others either did not respond at all or selected physicians who were not enrolled as sponsors.

MSA/MDSS tried several strategies to get unresponsive recipients to enroll. "Second notice" mailings were used for a short time, and, although the strategy yielded several new enrollments, it was considered too costly and was abandoned. Recipients who did not respond to either the first or second notice were randomly assigned, according to zipcode, to physician sponsors (80 percent) or to HMOs (20 percent). This resulted in many subsequent requests from enrollees for changes to a different sponsor. After a year, MDSS changed to computer-matched assignments, in which recipients were linked with geographically proximate sponsors who had actually served them in the past. This approach was also terminated after several months for the same reason.

During the first year of implementation, recipients who did enroll voluntarily but selected physicians who had not yet signed sponsor contracts were initially allowed to receive services as in the standard FFS program until their preferred physicians could be recruited into the program. This approach was

eventually replaced with a temporary, and unworkable, policy that required non-sponsored enrollees to obtain prior authorization for all non-emergency care from PPSP staff. This placed an enormous burden on the Sponsor Specialists, who could not keep up with the authorization requests, and consequently caused severe problems for providers and recipients alike.

By March, 1984, after 18 months of operation, 36,500 recipients (or 13 percent of the targeted 286,000) had enrolled in PPSP under the mandatory approach. In early 1984, the attempt to adhere to a strict mandatory enrollment policy and to manage care for unsponsored enrollees finally gave way to a more lenient--and administratively feasible--approach. Under this approach, recipients were encouraged to enroll as before but told they "might" be assigned to a sponsor if they failed to respond. Sponsor physicians were now allowed to encourage recipients to enroll and public assistance caseworkers promoted enrollment during eligibility and redetermination meetings with recipients.

Between March and September, 1984, another 17,400 recipients enrolled in the PPSP, bringing the total to 53,900, or 19 percent of the target population. In terms of the number of enrollments per month, there was little difference in effectiveness between the strict mandatory approach to enrollment and the more lenient approach adopted two years into the program. The mandatory approach, however, had severely stressed MDSS/MSA resources and created ill-will among recipients and providers.

Administering PPSP

During Federal FYs 1983 and 1984, the first two years of PPSP implementation, MDSS/MSA spent $712,000 and $733,000 to administer the program. Each year, slightly more than half of the amount spent on administration was devoted to Sponsor Specialist operational staff, about one-third to computer program enhancements and operations, and about one-seventh to MDSS/MSA administrative staff. PPSP administrative costs represented about 2 percent of expenditures for medical services to PPSP enrollees. In FFY 1984, it cost about $14 per enrollee per year to administer the PPSP and FFY 1985 costs were projected at $5 per enrollee per year.

During PPSP's early years, major administrative tasks (and problems) included the following: (1) providing information to physicians and recipients both before and after enrolling in the program (resources were generally inadequate to meet the demand for information, with several major bottle necks at critical times); (2) assuring sponsor compliance with contract provisions, generally by providing information to sponsors to facilitate their role and contracting program monitoring from an external recipient rights agency (this agency found that many sponsors were not following proper procedure regarding 24-hour access); (3) assuring cost-effective delivery of services through routine monitoring of utilization patterns and corrective actions (several mechanisms intended to accomplish this task have not been implemented); (4) assuring quality of care (beyond what was done in the standard program, no mechanisms were established in this area); and (5) paying claims and case management fees in a timely fashion (no apparent problems in this area).

Containing Costs

Early, and very limited, monitoring data suggested that PPSP enrollees were experiencing lower rates of service utilization and expenditures than non-PPSP enrollees. PPSP saved $13.51 per enrollee year for FFY 1985. The PPSP savings were found to be almost seven times greater in a recent three-year, randomized control group analysis of PPSP utilization and expenditures during a 12-month period in 1984-85.(1) In that study of 3,065 enrollees and 5,212 controls, PPSP savings were estimated at $104.26 per enrollee year. If these savings were generalizable to the entire PPSP population, then the PPSP would have saved over $4.8 million in 1984.

Savings varied by sub-group of PPSP enrollees. PPSP saved an average of $758 per enrollee year for individuals who had been high service users prior to enrollment; it saved much less, $149, among prior medium users and cost $16 more

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1. This evaluation was conducted by MDSS under a grant from HCFA's Office of Research and Demonstrations. The study, which was completed in late 1986, focused on PPSP impact with respect to utilization, savings, and enrollee satisfaction with medical care. A full report of the evaluation is available in R. Douglas Kosinski, Randy Knapp, Karen J. Carty, and Rose Ann Ward, The Impact of the Physician Primary Sponsor Plan on the Medicaid Program in Michigan, Planning and Evaluation Division, Office of Planning, Budget and Evaluation, Michigan Department of Social Services, September, 1986.

for each prior non-user. In addition, PPSP is estimated to have saved an average $155 per enrollee year for ADC (AFDC) recipients, but cost $52 more for SSI recipients. Within ADC, PPSP saved almost twice as much among adults as among 15-21-year-olds, and it cost more among children aged 0-14. These differences among groups suggests that the program was having positive redistributive effects: children were generally receiving more essential services and adults were receiving fewer inappropriate services under case management than had been the case under the standard fee-for-service program.

These and other findings from Michigan's utilization and cost analysis are encouraging, but they should be viewed cautiously. Although the MDSS study is one of the most careful and thorough assessments of PCCM effects available, it had major limitations. For example, the analysis of utilization and costs excluded all PCCM enrollees and FFS recipients who were not continuously eligible for Medicaid during the 12 months preceding and the 12 months following enrollment of the PCCM sample. This exclusion left out a substantial number of recipients, probably more than one-half, whose utilization patterns would be expected to differ systematically from those of the continously eligible. There was also high attrition for the PPSP sample back into regular FFS because PPSP participation was not mandatory as originally intended.

Access and Quality of Care

Despite the restriction of freedom of choice and the potential negative effects of early attempts to assign recipients to providers, the available evidence suggests that PPSP recipients are generally as satisfied with access and quality of care as their FFS counterparts. MDSS conducted a pre-post survey of PPSP enrollees and FFS recipients' attitudes and perceptions. In all, 1,428 PPSP enrollees and 1,560 FFS recipients answered both questionnaires; about 30 percent of the respective samples of 5,000 each. In addition, the Michigan League for Human Services (MLHS) conducted a monthly survey of new PPSP enrollees and a resurvey of respondents six months later.

The MDSS pre-post survey showed that about two-thirds of those in need of care in both groups were able to schedule an appointment within two days. The percentage of FFS recipients waiting more than two weeks for an appointment,

however, was more than double PPSP at 15.6 percent. There were no other significant differences in access reported. In both groups, 85-90 percent of recipients were able to reach their provider's location within 30 minutes and about one-half had office waiting times under 30 minutes. The survey also showed that 82 percent of respondents were still enrolled with their initial PPSP case manager physician.

The MLHS monitoring surveys indicated similar, or slightly more positive, findings about geographic access, e.g., a higher percentage of PPSP enrollees reported travel times to providers under 30 minutes than in the MDSS survey. The MLHS data also indicated areas where access can be improved. For example, 23 percent of MLHS respondents reported a need to contact their physician after regular office hours, but a third of this group had difficulty making contact and some turned to emergency room care instead.

In terms of perceptions of quality, a very small percentage of MDSS survey respondents gave a "poor" rating to the technical quality of care: 2.2 percent of FFS and 3.0 for PPSP. About eighty percent rated it "excellent" or "good". Nonetheless, the differences on this and other queries related to quality revealed that PPSP enrollees' preceptions of quality were lower than FFS recipients. The MLHS monitoring also included enrollees' "assessment of care under PPSP". Fifty-three percent of the 1025 respondents reported that care was the "same", but the number under PPSP indicating that care was "better" was almost double the number reporting that care was "worse".

In terms of overall satisfaction, the MDSS survey showed that the largest share of recipients in PPSP preferred to return to FFS (51.5 percent) but about 33 percent indicate a definite preference to stay in PPSP. The remainder were undecided. The MLHS monitoring, however, identified important differences in perceptions of satisfaction between recipients who were enrolled with physicians they were seeing already and those enrolled with a physician they had not seen before. The latter were less satisfied with their Medicaid care before PPSP and considerably less satisfied after PPSP experience. This group is perhaps most likely to feel the constraint on freedom of choice, hence their lower opinion of the program.

One of the most interesting findings from MLHS monitoring is that 80 percent of the respondents were enrolled with a physician they were already seeing before PPSP. This suggests that PPSP represents little or no change for most enrollees, which helps to explain why perceptions of access and quality did not change dramatically.

Finally, PPSP probably increased the percentage of Medicaid enrollees using the same primary care physician as their regular point of contact for medical care. According to previous research, specifically NCHR's "Usual Sources of Medical Care and Their Characteristics" (October, 1982), almost half of a population of Medicaid recipients would be expected to have no usual source of care or receive care at hospital outpatient departments (including ER) health centers, etc. Under PPSP every recipient has a case manager, so there should be an improvement in the regular source of care for a sizeable share of recipients, especially those who are not enrolled with a physician they were seeing before PPSP.

CONCLUSION

Since PPSP seems to be achieving its intended results, the most fundamental finding is that implementation has occurred more slowly than expected. The original timetable presented to the legislature in October of 1981 called for recruiting hundreds of physicians and enrolling thousands of recipients by December, 1982. As of September, 1984, approximately 1,260 physicians and 54,000 recipients were participating in PPSP, but this was under one-half of the original targets for both groups. Since projected aggregated savings and other expected results are dependent on the level of implementation, the lag in implementation undoubtedly undercuts the level of benefits that can be achieved.

There are several reasons for implementation having been less complete than expected. The first and most obvious is that the original objectives and implementation schedule were overly ambitious, particularly considering the scope and complexity of the change involved in starting PPSP. In their haste to contain costs, legislators, state physician association representatives, and MDSS officials established timetables and expected levels of benefits that were implausible given past experience applying PPSP design concepts in Medicaid and

the resources allocated to the project.

The responsibility for this over-ambitiousness is shared at the federal level because of the emphasis on achieving savings quickly, rather than developing a workable PCCM system that operates at less cost than fee-for-service. While these are not incompatible aims, the pursuit of end results alone often implies that perfecting the means to these end results goes relatively unattended.

In retrospect, it seems that the timetable and resource requirements for achieving results were more of a problem for PSPP implementation than was the level of benefit that was projected. It seems obvious that the recession and specter of a state revenue shortfall created pressure to underestimate the time and resources that would be required to gain savings from PPSP. The lesson for other states is that significant results should not be expected soon after starting a PCCM and that planning and implementation are more time-consuming and resource-intensive than may be expected.

Another issue was the adequacy of administrative resources for combined implementation and continuing operation. Were enough made available? The cost of making change is generally greater than expected. Perhaps reflecting the same kind of pressure for results that spawns unrealistic schedules, implementation costs are often underestimated. This has the positive effect politically of making the proposal seem more effective or efficient, but it can mean sacrificing all or part of the end result if true implementation costs are avoided. For PPSP, there was not an implementation budget per se, so implementation and administration competed for the same resources. After the first few months, continuing administration costs, such as for managing recipients with MSA designation, began absorbing resources that were needed for marketing unenrolled recipients, thereby making it harder to advance implementation.

If a realistic schedule and sufficient resources had been present, there would have been some remaining tactical problems with PPSP implementation. The most basic, in our opinion, was the lack of a workable approach to managing the interrelated aspects of physician recruitment and recipient enrollment. At first, these two activities proceeded on separate tracks, causing difficult

logistical problems, such as a backlog of recipients who wanted to enroll with a non-sponsor primary care physician. In retrospect, it seems that these two key functions should have been managed more interdependently, perhaps targeting initial recipient enrollment efforts first at patients of physicians with sponsor contracts.

It is not apparent today that the problems encountered in starting PPSP have been resolved. There is no promising approach to attract a significantly larger number primary care physicians to PPSP and the problem of enrolling recipients at a pace fast enough to reach original targets in the near future remains. Soon MDSS will implement a pilot for mandatory enrollment in one section of Wayne County.

The MDSS is also experimenting with new strategies to enhance enrollment, physician participation, and other operational areas. Future plans include more targeting of high service users for case management, elimination of all co-payments for PPSP enrollees, consolidation of hotline operations for all assistance programs, development of cost standards and sanctions to discourage excessively high utilization among sponsor physicians, and development of rewards and penalities for efficient and inefficient sponsors. All of these changes indicate Michigan's strong commitment to moving the PPSP and managed care as a whole toward achieving its major implementation and impact goals. Michigan's process on this agenda will be crucial as other states also move to curtail or eliminate conventional FFS primary care.

CHAPTER 1
BACKGROUND OF PPSP

This case study report describes Michigan Medicaid's response to Section 2175 of the Omnibus Budget Reconciliation Act of 1981 (OBRA), which increased states' flexibility to restrict recipient freedom of choice of provider. Specifically, the report focuses on the implementation in Wayne County of the Physician Primary (Care) Sponsor Plan (PPSP), a primary care case management plan (PCCM) in which recipients enroll with a single physician, who thereafter provides and authorizes most non-emergency care. In accordance with the new Section 1915(b)(1) of the Social Security Act, a PCCM waiver was granted by the U.S. Department of Health and Human Services to the Michigan Department of Social Services (MDSS) to establish the PPSP.

The PPSP was selected for study as part of the Medicaid Program Evaluation because it is the largest, most fully implemented PCCM initiative in the nation. As of late 1984, it included about one-third of all Medicaid enrollees participating nationally in private physician PCCMs under 2175 waivers. This case study report documents the Michigan experience from early planning in mid-1981 through completion of the first 26 months of PPSP implementation in September, 1984.

1.1 LEGISLATIVE IMPETUS FOR PPSP

Prior to OBRA's passage in August, 1981, development of the PPSP was stimulated by the Michigan Legislature in the Appropriations Bill of 1981 (Public Act 35).(1) Passed in early 1981, this bill reflected the legislature's immediate concern for the effects of the recent recession on state revenue and a continuing concern over increases in Medicaid expenditures. Their desire was to curb aggregate expenditure increases. After several years of threatened and actual

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1. State of Michigan, 81st Legislature, Regular Session of 1981, Enrolled House Bill No. 4130, Public Act 35 of 1981, Legislative Service Bureau, State Capital, Lansing, Michigan.

decreases in the Medicaid reimbursement rates to physicians, the legislature recognized a need to try a new approach. Public Act 35 of 1981 included the following provision:

> Sec. 68. (1) In conjunction with associations representative of allopathic and osteopathic physicians and surgeons the House and Senate Appropriations Subcommittees on Social Services shall develop, through negotiations, an alternative reimbursement system for physicians. Agenda for the negotiations shall include: (a) a case management "lock-in" approach, (b) a capitation mechanism, (c) a pre-paid comprehensive health maintenance organization approach, and (d) protocols for utilization management, but shall not exclude other utilization management methods of reimbursement. A report detailing this system shall be submitted for approval to the House and Senate Appropriations Subcommittees on Social Services by August 1, 1981.
>
> (2) The additional $6,676,200.00 appropriated to physicians in Section 1 shall be allocated as an incentive fee to providers participating in the alternative system.
>
> (3) The change required in subsection (1) shall be implemented by October 1, 1981. If the Department of Social Services has not reached agreement with providers by August 1, 1981, the Department, with the concurrence of the House and Senate Appropriations Subcommittees on Social Services, shall proceed toward implementation of a revised reimbursement system by October 1, 1981.

In essence, the legislature suggested moving away from fee-for-service reimbursement toward, perhaps, some type of capitated or pre-paid plan. The MDSS, the Michigan State Medical Society (MSMS), and the Michigan Association of Osteopathic Physicians and Surgeons (MAOPS) were assigned the responsibility of developing an alternative primary care delivery plan for Medicaid.

1.2 DEVELOPING THE CONCEPT

A joint MSMS and MAOPS Task Force, in consultation with the MDSS, began developing a proposal for a Medicaid primary care alternative on May 20, 1981. The Task Force resurrected and enhanced an idea suggested by the MSMS in the early 1970s, when Michigan first embarked on Medicaid cost containment. At that time, the Legislature requested that the MSMS develop a list of cost-saving measures. Among other proposals, the MSMS suggested recording a single physician's name on each recipient's Medicaid ID card. This idea led to the no-

tion of physician in the role of case manager, with continued reimbursement of the physician on a fee-for-service basis. The Task Force's final proposal, then, called for control of utilization, not revision of the reimbursement system.(2)

The Task Force proposal identified several fundamental issues of program design that would be debated during the following months. For example:

- Should an "incentive administration fee" be paid in addition to fee-for-service reimbursement?
- Should sponsor types include individual physicians, group practices, clinics, and institutions (e.g., out-patient hospitals)?
- Should referral forms be used by sponsors to authorize specialty or other non-primary care?
- Should the term "lock-in" be used to describe the sponsor-enrollee relationship?

The MSMS and MAOPS Task Force proposal, which was approved by both groups' executive boards in July, 1981, called for an experimental alternative reimbursement system for physicians under Medicaid, which locks in recipients with a primary sponsor. According to the proposal, the system would have the following major features:

1. Medicaid eligibles shall select a primary sponsor (control physician or provider) of choice, provided the sponsor agrees to accept the recipient. Either party wishing to terminate the arrangement may do so upon reasonable notice and for justifiable cause. (To be defined.) The Department of Social Services shall notify each primary sponsor of his/her/its assigned patients for the coming month no later than three days prior to the beginning of said month.

2. Medicaid eligibles shall be given 60 days from the beginning of the enrollment period to voluntarily select their primary sponsor. A plan shall be developed jointly by MDSS, MAOPS and MSMS for enrolling eligibles who have not selected a primary sponsor after 60 days.

3. In recognition of the additional services required of the primary sponsor (continuous responsibility, accessibility, the process of control, preauthorization of services, cost constraints), incentive administrative fees shall be authorized. The actual amount and process

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2. Government Liaison, Michigan State Medical Society, site visit, June 1984.

by which it is rendered to the primary sponsor shall be the subject of additional discussions among MDSS, MAOPS and MSMS.

4. Each physician contact by the recipient shall be paid on a fee-for-service basis structured to discourage overutilization. Examples of incentives shall be:

   a. Parity reimbursements for ambulatory services regardless of setting. In particular, total reimbursement for hospital freestanding clinic services shall not exceed comparable office based services.

   b. Higher reimbursement for office surgical procedures.

5. Physicians enrolled as participating physicians in the Medicaid program shall be eligible for participation in this program. MDSS should monitor primary sponsors enrolled in this program and clarify its authority to act expeditiously to disenroll any physician abusing the program.

6. This program is recommended on a pilot basis. Targeted areas shall contain a significant Medicaid population and participating physicians so as to obtain a representative cross section of sick and healthy eligibles.

The physicians' proposal did not specify which Medicaid recipients, if any, should be excluded from the PPSP. At some point in the design process MDSS decided to exclude the following major groups of recipients: institutionalized long-term care recipients, Medicare-Medicaid dual eligibles, and crippled children. As these groups represented a relatively small proportion of eligibles, the program was available to most AFDC and SSI Medicaid eligibles.

In addition, the MSMS/MAOPS Task Force proposal called for education of recipients and physicians about the need for and nature of a case management system, parity between Medicaid and Medicare reimbursement rates, the primary sponsor's responsibility for rendering or authorizing all care, MDSS monitoring of primary sponsors, reports to sponsors of all referral services received by each recipient under their care, more and better-reimbursed office-based surgery, and "lock-in" for recipient overutilizers.(3)

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3. Michigan State Medical Society and Michigan Association of Osteopathic Physicians and Surgeons, Physicians' Proposal for Utilization Management. An Alternative Reimbursement System Under the Michigan Medicaid Program, July, 1981 (Attachment 1.1).

Legislative approval for the physicians' proposal, named the Physician Primary Sponsor Plan (PPSP), came in early October 1981.(4) It was suggested that the MDSS should begin phasing-in PPSP as a pilot project in January, 1982, allowing just three months to develop the plan and market it to physicians.(5) A Steering Committee was established to develop and implement PPSP. Membership included representatives from the MSMS, MAOPS, MDSS, and the Medical Services Administration (MSA), the lead agency for Medicaid in MDSS. Several former Task Force members joined the Steering Committee, and staff from MSMS and MDSS shared its directorship. The Steering Committee first met at the end of October, 1981, the same month that the legislature had originally specified in P.L. 35 for the new plan to begin.(6)

1.3 GETTING STARTED

A. Obtaining Waivers to HCFA Regulations

The MDSS needed approval from the United States Department of Health and Human Services, Health Care Financing Administration (HCFA), in order to implement PPSP in Wayne County. Specifically, the MDSS applied for a waiver, under Section 1915(b)(1) of the Social Security Act, of three other sections of the Act: 1902 (a)(1), (7), and (23). Michigan was one of the first states to seek such waivers and take advantage of the opportunity for increased flexibility.

The following are the HCFA guidelines to the States for development of a primary care case management program under Section 1915(b)(1).(7)

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4. S. Monsma and D. Hollister, letter to the Director of the Medical Services Administration, Michigan Department of Social Services, October 2, 1981.

5. James Fryfogle, "New Medicaid Program to Start in Wayne County. Physicians' Primary Sponsor Plan Accepted by the State," memo, Michigan State Medical Society, October 30, 1981.

6. John Dempsey, letter to Dr. A. Turcke, Michigan State Medical Society and Dr. W. Anderson, Michigan Association of Osteopathic Physicians and Surgeons, October 5, 1981.

7. Senate Finance Committee Staff, "New Approaches to Providing Acute Care Services to the Poor: Medicaid Freedom of Choice Activities," February 1984.

Primary Care Case Management System (Section 1915(b)(1). -- Section 1915(b)(1) allows states to implement primary care case management systems or specialty physician services arrangements. Under these programs, a state may restrict the provider from or through whom a recipient can obtain medical care services. Restrictions may not apply to emergency services, nor may access to services of adequate quality, where medically necessary, be impaired.

Under a primary care case management system, a state must assure that a specific person or persons or agency will be responsible for locating, coordinating, and monitoring all primary care and other medical care and rehabilitative services on behalf of a recipient. Primary care includes a range of services adequate for meeting the great majority of personal health needs. Primary care is ordinarily provided by family practice physicians, internists, pediatricians, or physician surrogates (physician assistants, nurse practitioners, pediatric associates, etc.). A primary care case management system, in addition to providing primary care, provides or arranges for a full scope of personal health care including primary, intensive, and highly specialized services. A primary care case management program may include the provision of, or arrangements for, all available services as long as primary care services are provided as well.

On November 10, 1981, the MDSS applied for a waiver from HCFA.(8) The MDSS asked HCFA to waive three sections of the Social Security Act:

1902(a)(1). The application of the Medicaid program must be statewide.

The MDSS requested a waiver of section 1902 (a)(1) because they did not want to implement PPSP throughout Michigan. They planned first to try PPSP in Wayne County and then consider implementation in other counties.

1902(a)(7). There must be provision of safeguards which restrict the use of disclosure of information concerning recipients for purposes connected with administration of the Medicaid program.

The MDSS requested a waiver of section 1902(a)(7) because they wanted to send periodic reports to primary care sponsors listing all of the services received by recipients in their caseload, including services rendered by other physicians. "In order to perform the case management function and effectively monitor a recipient's health care, the primary sponsor must have data concerning that recipient's utilization of services from other providers." The MDSS left

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8. John Dempsey, letter to Judith Stec, Director, Division of Program Operations, DHHS Region V, November 5, 1981.

it up to the sponsors to exercise "confidentiality according to their professional standards."

> 1902(a)(23). Recipients have the freedom of choice to receive medical assistance from any provider.

The MDSS requested a waiver of section 1902(a)(23) because recipients, once enrolled in PPSP, would be limited to medical care rendered and authorized by their sponsor physician. However, the MDSS pointed out that recipients would be "allowed to choose from available providers participating in [PPSP], and, with notice, change providers."

Waivers are generally granted for a two-year period. The PPSP waiver began July 1, 1982, and expired on July 1, 1984. A little more than half way through, on November 28, 1983, Michigan applied for and received a modification to their waiver. The modification waived section 1902(a)(10) of the Social Security Act, which requires provision of comparable medical services to all recipients. Michigan used this modification to exempt PPSP enrollees from co-payments on prescription drugs.

After the July, 1984, expiration, the state continued to operate the PPSP until further notice from HCFA. HCFA formalized their questions about PPSP in a letter sent August 15, 1984.(9) On September 12, 1984, the MDSS resubmitted their request for a two-year renewal of the waivers for PPSP.(10) In December, 1984, HCFA granted a one-year extension of the PPSP waiver, back-dated to July 1, 1984. After June 30, 1985, HCFA would consider granting Michigan a new two-year waiver. In the approval letter, HCFA emphasized that the Michigan analysis should focus on the cost savings impact of PPSP:

> To permit the continuation of the project beyond June 30, 1985, the state must produce more comprehensive data than are currently available regarding the cost-effectiveness of the waiver . . . . In addition, the state must be able to document that access to services under the

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9. Barbara Gagel, Regional Administrator, letter to Agnes Mansour, Director, Michigan Department of Social Services, August 15, 1984.

10. Agnes Mansour, letter to Barbara Gagel, September 12, 1984.

project is not being substantially impaired.(11)

In addition to the PPSP waiver, Michigan received waivers for two other delivery plans being tested in Wayne and other counties: a Health Maintenance Organization (HMO) program and a Capitated Ambulatory Plan. These waivers were important because where possible, the MDSS wanted to offer recipients a choice among case management options: PPSP, HMO or CAP. First, the MDSS applied for a 1915(b)(4) waiver of Social Security Act section 1903(m)(2)(A)(vi), which requires that Medicaid recipients enrolled in HMOs have the option to terminate enrollment, without cause, within a month after making the request for enrollment termination. The 1915(b)(4) waiver would allow Michigan to require recipients to obtain services only from specified providers who meet specified reimbursement, quality, and utilization standards.(12) The MDSS requested a waiver of this section in order to "lock-in" new Medicaid recipients in HMOs for six months. HCFA granted the waiver and the policy became effective January 1, 1982. On January 1, 1984, HCFA granted the MDSS a two-year extension of the HMO waivers.

Second, under section 1915(b)(1), the MDSS received waivers to implement a Capitated Ambulatory Plan (CAP). Under the CAP, special clinics would operate basically like HMOs, except that they would not provide inpatient hospital services. The CAP would not be implemented statewide; therefore, the MDSS wanted to waive section 1902(a)(1). CAP enrollments would limit the recipients' choice of providers; therefore, the MDSS wanted to waive section 1902(a)(23). The MDSS requested a waiver of section 1903(m)(2)(A)(i) because the clinics involved in the CAP were limited in their operations and did not include in-patient hospital services. The MDSS did not want to require that the clinics apply for licensure as an HMO, but they wanted to pay the clinics on a risk basis. Finally, the MDSS wanted to waive section 1903(m)(2)(A)(ii) which requires that the clinics' pre-paid Medicaid enrollee population be no higher than 75 percent of the total

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11. Carolyne Davis, Administrator, Health Care Financing Administration, U.S. Department of Health and Human Services, letter to Agnes Mansour, December 14, 1984.

12. Health Care Financing Administration, "State Organization and General Administration 2107," State Medicaid Manual, Part 2 -- State Organization, p. 12.

CAP population. Because the participants in the CAP program would most likely all be Medicaid recipients, the clinics' CAP enrollee population would most likely exceed the 75 percent Medicaid population limit. HCFA granted all of the waiver requests and the CAP became effective on April 22, 1983.(13)

B. Agreeing on a Sponsor Contract

Upon waiver approval, the MDSS set about developing a contract for use with each of the physicians who would serve as primary care physician sponsors. The MDSS and representatives of physician organizations reached agreement over the basic terms and conditions of the sponsor agreement in seven months, at comparatively low cost in time and effort. Rapid agreement was reached because the MDSS and the physician representatives (MSMS/MAOPS) each saw advantages in various aspects of the sponsor agreement. The physicians liked the basic plan because only minor constraints on practice were imposed and case managers would earn a fee of three dollars per month per recipient. The fee was to help offset any added cost of serving PPSP enrollees. As such, it represented a de facto Medicaid reimbursement rate increase -- the first since 1976. From the perspective of MDSS, the sponsor contract provided improved leverage for assuring appropriate use of Medicaid services, prudent financial management on the part of physicians and reductions in service utilization and expenditures. In short, MDSS and physician organizations viewed the sponsor contract as a viable way to meet the Michigan Legislature's mandate for cost containment in Medicaid primary care.

The sponsor contract represented the first written agreement between the MDSS and physicians governing Medicaid services.(14) This agreement -- which delineated the roles and responsibilities of MSA and physicians -- established the basic plan for operating PPSP.

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13. John T. Dempsey, letter to Phillip Nathanson, Regional Administrator, DHHS, HCFA Region V, February 19, 1982 and November 25, 1981.

14. S.N. Wellman, "The Healthy Adversaries: Executive, Legislative, and Interest Group Relations in the Michigan Medicaid Program," Michigan State Medical Society, March, 1978.

One way in which its originators hoped the contract would be used was as a legal lever to modify or exclude participation in Medicaid by undesirable physicians, that is, physicians with patients who have a pattern of inappropriate or excessive service utilization. Accordingly, having defined the basic terms of the contract, the Steering Committee decided to use two versions. A "standard" contract was used for most physician sponsors. A few physicians with a history of patients with high utilization in comparison to the average for like physicians were given "provisional" contracts. These provisional contracts were identical to the standard contract except for a clause stating that the MDSS could hold the physician's case management fee in escrow. In part, the clause stated:

> If the sponsor meets the cost standards established by the Department pursuant to Addendum A of the contract for each of the first four quarters of the contract period, the funds held in escrow plus interest for each of the quarters shall be delivered to the sponsor. . . If the cost standards are not met for all of the first four quarters of the contract period, the sponsor shall be disenrolled from the plan and the funds held in escrow for the quarters for which the standards were not met and for all subsequent quarters shall revert to the department.(15)

By putting the case management fees in escrow, the MDSS would have the time to monitor carefully and rigorously the recipient utilization patterns of sponsors with provisional contracts. In addition, the contract was expected to give the MDSS a legal basis to terminate the contracts of "provisional" sponsors who exceeded cost standards.

C. Planning for Implementation

The sequence of observable events and activities that were expected to accomplish PPSP objectives is presented in Exhibit 1.1. It indicates the major relationships among implementation events and objectives. For example, the marketing of PPSP contracts to physicians -- Event 2 -- depended to a large extent on gaining prior agreement with physician organizations about the terms and

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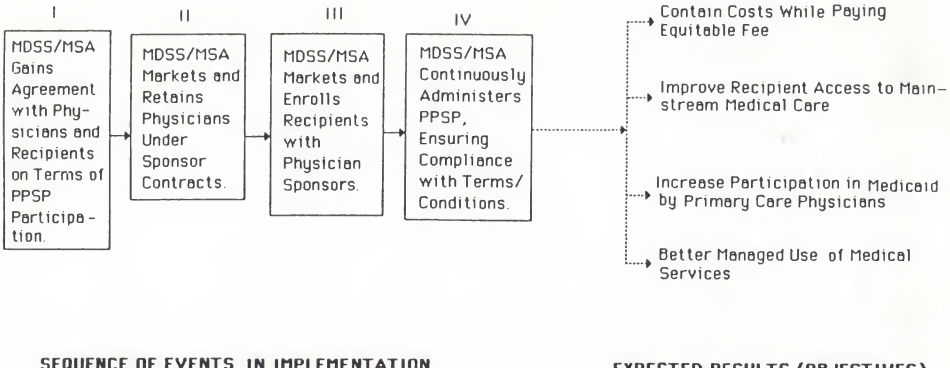
15. Michigan Department of Social Services, "Medical Assistance Program, Physician Primary Sponsor Plan Contract, p. 5a, June 1, 1982. A copy of the contract, with the clause for "provisional" sponsors (Clause 24) and later amendments, is provided in Attachment 1.2.

EXHIBIT 1.1: PPSP IMPLEMENTATION


I
MDSS/MSA Gains Agreement with Physicians and Recipients on Terms of PPSP Participation.
II
MDSS/MSA Markets and Retains Physicians Under Sponsor Contracts.
III
MDSS/MSA Markets and Enrolls Recipients with Physician Sponsors.
IV
MDSS/MSA Continuously Administers PPSP, Ensuring Compliance with Terms/Conditions.
Contain Costs While Paying Equitable Fee
Improve Recipient Access to Mainstream Medical Care
Increase Participation in Medicaid by Primary Care Physicians
Better Managed Use of Medical Services
SEQUENCE OF EVENTS IN IMPLEMENTATION
EXPECTED RESULTS (OBJECTIVES)

conditions appearing in the contract -- Event 1. Similarly, the achievement of better managed use of medical services depended on physician and recipient participation -- Events 2 and 3 -- and MSA administration of physician's management of care -- Event 4.

Clearly, the logic of PPSP implementation is much more complex than that represented in Exhibit 1.1. The exhibit excludes many factors such as the supply of non-Medicaid patients and other influences on physician participation in PPSP or other Medicaid initiatives. Nonetheless, it establishes a basic framework for further describing and assessing the process of implementation.

As noted above, the revised target date for starting the PPSP was January, 1982. The Steering Committee intended Wayne County (Detroit) to be the first pilot site and Muskegon County to be a second pilot site. While developing the proposal, the committee worked on a range of issues relating to physicians, including a physician "application," high cost or abusive providers, eligible physician specialty types, informing providers about the proposal, creation of a physician work group in Wayne County to assist in obtaining physician support, and developing goals for cost effectiveness and quality of care.(16)

The Steering Committee quickly realized that it would be unable to meet the January, 1982, implementation date for two main reasons. First, the participating organizations underestimated the length of time involved in designing, reaching agreement on, and starting PPSP. Second, there were continuing disagreements among participating organizations about the design and goals of PPSP. For example, while MDSS and providers wanted to try PPSP in Wayne County, recipient representatives wanted a test at a smaller site. Representatives for recipient advocacy groups raised many issues (discussed below) in addition to concerns raised by the state and local medical societies. By early January, 1982, the Steering Committee decided to postpone implementation until July 1, 1982.

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16. Physician Primary Sponsor Plan Steering Committee, "Agenda Item 9, Areas of Concern," October 29, 1981.

1.4 REACTIONS TO THE PLAN

A. Recipients and the Consultation Group

Neither Wayne County Medicaid enrollees nor their representatives were integrally involved in developing the PPSP proposal submitted to the Legislature in August, 1981. However, within a few months, recipients were more active in the continuing development and implementation of PPSP. To ensure representation of recipient concerns, the Steering Committee considered two options, recipient representation on the Steering Committee or use of a "Consultation Group." The Steering Committee selected both options.(17) By the January, 1982, Steering Committee meeting, one recipient had been added to their membership and the Consultation Group had been established. The Consultation Group's membership shifted over time, including participation by the public health department in Wayne County, HMO representatives, welfare rights groups, the Welfare Reform Coalition (an alliance of 45 organizations), and the Better Health Care Coalition.(18) It submitted 37 questions about the effect of PPSP on recipients and reacted "favorably" to the Steering Committee's response to the questions.(19)

After receiving answers to their questions, the Consultation Group made six recommendations in a May 3, 1982, letter to the Steering Committee: 1) maintain the "pilot" status of PPSP, enroll no more than 10,000 recipients over a four-month period, and evaluate the group for six months before enrolling any more recipients; 2) develop a patient contract and specify recipient rights; 3) more actively ensure quality of care standards; 4) make monthly comparisons of PPSP to the Kalamazoo CAP; 5) designate a monitoring committee to review PPSP implementation; and (6) ensure sufficient "Hotline" staffing and hire skilled

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17. Physician Primary Sponsor Plan Steering Committee, "Agenda Item 9, Areas of Concern," October 29, 1981.

18. Maryann Mahaffey, Councilwoman to the City of Detroit, telephone interview, April 1985.

19. Physician Primary Sponsor Plan Steering Committee, Minutes, January 28, 1982.

social workers to respond to recipients' PPSP needs.(20)

In addition, the Consultation Group registered two important general concerns in its letter. First, in light of the cutbacks in many assistance programs, PPSP was viewed as another potential decrease in service to recipients. There were insufficient safeguards for patients, no quality of care standards, and no grievance procedures. Second, it was unclear that the state could be assured any savings from PPSP. There were no incentives for physicians to practice more cost-effectively, there was no financial risk for physicians, and the administrative costs of PPSP were unclear.

The Consultation Group strengthened their arguments in a May 5, 1982, letter to the Steering Committee, less than two months before scheduled implementation on July 1. They discussed the following five "questionable assumptions" about PPSP:

- Escalating Costs to the State of the Medicaid Program. Because sponsors were not at financial risk for hospital expenditures, the Consultant Group saw no incentive in PPSP to reduce these costly expenditures.

- Overutilization of Benefits by Recipients. While AFDC recipients made up 78.6 percent of the Medicaid population, they accounted for only 37.7 percent of expenditures. PPSP targeted the wrong group of recipients. (Crippled children, long-term care patients and Medicare eligibles are excluded from the PPSP).

- Overutilization by Providers. If the goal was to have a contract with physicians in order to have a mechanism for trying to remove overutilizing physicians from Medicaid, there were other options through OBRA 1981 to achieve this goal without involving recipients (e.g., selective contracting).

- Access for Clients to Quality Health Care. If PPSP was attempting to improve access to care, it targeted the wrong group of recipients. Access was actually limited in areas where there were only a few physicians participating in Medicaid. This included Macomb and Oakland Counties, but not necessarily Wayne County.

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20. Maryann Mahaffey, Better Health Care Coalition, letter to the Director of the Primary Physician Sponsor Plan Steering Committee, May 3, 1982.

- o Quality Care for Recipients. Physicians considered the case management fee a deserved increase in pay rather than an incentive to better manage their patient's care.(21)

Partly in response to some of the concerns of the Consultation Group and Detroit Coalition, the Steering Committee did three things. First, they developed a notice to be sent with Medicaid cards to advise recipients to begin considering whom they would like to choose for their sponsor.(22) Second, working with the Consultation Group, the Committee developed a complaint/grievance process. Third, the Steering Committee hired the Michigan League for Human Services (MLHS), an influential and respected recipient advocacy group in the state, to monitor the effects of PPSP implementation on recipients. While these were perceived as improvements to the PPSP plan, they did not address the fundamental concerns registered by the Consultation Group.

B. WELFARE RIGHTS ORGANIZATIONS

During the May 10, 1982, Steering Committee meeting, representatives from two other groups, the Parkside Welfare Rights Organization and the Community Welfare Rights Organization, raised two concerns. First, they were unsure about the "lock-in" approach. There seemed to be many protections for sponsors but few for recipients. Second, they were concerned about the availability of MSA Sponsor Specialist staff who were expected to handle the anticipated high volume of calls from recipients being marketed for PPSP. (As later events would prove, this second concern was highly warranted.)

Also in May, the Metropolitan Detroit Welfare Reform Coalition sent a letter to the Steering Committee pointing out concerns about recipient participation in PPSP. The Coalition was generally concerned about the overall plight of Medicaid recipients who had endured cuts across most major aid programs. Many of the Coalition's specific concerns were similar to those of the Consultation Group. The Coalition also felt that bilingual PPSP sponsors were needed, ap-

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21. Maryann Mahaffey, Better Health Care Coalition, letter to the Director of the Medical Services Administration, May 3, 1982.

22. Primary Physician Sponsor Plan Steering Committee, "Draft Medicaid Card Stuffer," May 10, 1982.

propriate 24-hour access had to be assured, and the 15 days given to recipients to select a sponsor were inadequate.(23)

C. Wayne County Medical Society

The Wayne County Medical Society (WCMS) quickly indicated to the Steering Committee that they wanted to be integrally involved in the development of the sponsor contract. In a January, 1982, letter to the Steering Committee, the WCMS raised three contract issues:

(1) the data base used to develop the standards for determination of over-utilization [i.e., the determination of physicians who receive standard vs. provisional contracts] must be "understandable and acceptable;"

(2) there must be parity in reimbursement to sponsors in private offices and sponsors in clinics or hospital out-patient facilities; and

(3) the method for disbursement of potential savings from PPSP must be made clear. (The PPSP contract did not specify any approach for reinvesting savings in the Medicaid program, in the form of service enhancement or any other improvements for recipients.)(24)

The WCMS did participate in developing the sponsor contract but a second letter, in May, 1982, indicated dissatisfaction with five specific contract provisions:

(1) MDSS's ability to take action against a sponsor prior to the completion of the appeals process, and without review by the Peer Review Committee;

(2) the fact that chiropractic and podiatric services did not require sponsor authorization;

(3) MDSS's ability to assign recipients to sponsors;

(4) the requirement that medical societies cooperate in the prohibition of sponsor advertising, which WCMS argued would violate the AMA Code of Ethics; and

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23. Constance Soma, Metropolitan Detroit Welfare Reform Coalition, letter to the Director of the Primary Physician Sponsor Plan Steering Committee, May 5, 1982.

24. Wayne County Medical Society Representative on the Steering Committee, letter to the Chairman of the Steering Committee, January 25, 1982.

(5) MDSS's ability to sanction pediatricians who did not encourage young recipients to participate in the EPSDT program.(25)

The Steering Committee considered the WCMS's objections, but, for the most part, did not change the contract provisions. It did agree to allow some peer review before taking action, but, this peer review was not comprehensive enough to satisfy the WCMS.

D. Michigan Association of Osteopathic Physicians and Surgeons

In May, 1982, the Executive Director of the MAOPS wrote to the MSA, refusing to endorse the sponsor contract. Specifically, the MAOPS took exception to the section in the "provisional" contract which gave the MDSS authority to take unilateral action against "provisional" sponsors without the consent of the Peer Review Advisory Committee.

> In Paragraph B21, on pages 4 and 5, there are three ways in which the Department may determine that a provider has exceeded utilization measures. First would be a determination by a Peer Review Advisory Committee. Second would be an adverse action relating to utilization taken under the Michigan Administrative Code. Third would be an emergency action taken by the Department under the Social Welfare Act to protect public health or the fiscal integrity of public funds. These latter two actions do not specifically require the consent of a Peer Review Advisory Committee. Accordingly, there is no absolute legal guarantee that the Department would not take action against utilizers without the consent of a Peer Review Advisory Committee. We take exception to this potential unilateral action as we have in the past. We do not agree with this potentiality and wish to go on record as being opposed to any type of unilateral action on the part of the Department against a physician participating in the PPSP.(26)

Upon implementation of PPSP, the MDSS consented to a review by a Peer Review Committee for the second action, but not the third. Dissatisfaction of the MAOPS with this provision in the contract became one of the issues in litigation brought against the MDSS, which is discussed below.

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25. Wayne County Medical Society Representative on the Steering Committee, letter to the Director of the Medical Services Administration, May 6, 1982.

26. Executive Director, Michigan Association of Osteopathic Physicians and Surgeons, letter to the Acting Director of the Medical Services Administration, "RE: Physician Primary Sponsor Plan Contract," May 14, 1982.

1.5 LITIGATION LEADS TO SOME CHANGES

Dissatisfaction raised by the MAOPS and the WCMS foreshadowed litigation brought by some disgruntled physicians. The litigation delayed implementation of PPSP for about three months, but did not substantively alter the terms of the sponsor contract or the design of PPSP. On July 7, 1982, six days after PPSP's official start, the Circuit Court for Wayne County issued a Temporary Restraining Order (TRO) and a Show Cause Order requiring the MDSS "to show cause . . . why they should not be restrained from implementing the Physician Primary Sponsor Plan Contract."(27) The TRO halted recipient enrollment, although the MDSS was allowed to continue its efforts to negotiate PPSP contracts with physicians. The plaintiffs in the suit were 50 osteopathic physicians, five MDs, and three recipients. The five issues raised in the TRO reflected many of the major concerns of the Wayne County Medical Society about the sponsor contract (discussed above). In addition, some specialists were concerned that they would lose their Medicaid patients.

First, physicians were disturbed about a 1500 patient caseload limit per sponsor. For example, five of the plaintiffs expressed concern because they were the only physicians in a clinic which served between 10,000-15,000 Medicaid recipients. According to the design of PPSP, if all of the physicians in this clinic were to become sponsors, this clinic's total practice would be limited to 7,500 patients (i.e., 1,500 patients for each of the five physicians). This would force the clinic to limit their Medicaid practice and expand their private pay practice in order to remain financially viable.(28)

Second, the plaintiff physicians were opposed to the "95th percentile" provision which could result in MDSS termination of the physician's contract.(29) According to the sponsor contract, "any physician who exceeded the

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27. Vicki Belin, Nadine Miller, et al., vs. Noble Kheder, Michigan Department of Social Services, "Verified Complaint for Injunctive and Other Relief," Civil Action Case No. 82-225, 143-CK, In The Circuit Court For The County Of Wayne, State Of Michigan, July 1, 1982, p. 23.

28. Ibid., p. 7.

29. Ibid., p. 3.

95th percentile (for sponsors with similar size caseloads) in average per recipient cost for any three-month period for in-patient, out-patient hospital, physician, pharmacy, laboratory, and radiology services, either by separate category or in total, may, at the option of the Department [MDSS] be disenrolled from the Plan [PPSP] and his contract (may be) terminated." (As it turned out, by late 1984; no physician's contracts had yet been terminated for exceeding the 95th percentile.)

Third, the contract gave the MDSS the authority to terminate a sponsor contract at any time. The physician could then appeal the decision and have the case brought up for peer review and an administrative hearing. The physicians wanted the opportunity to have a peer review and an administrative hearing before the MDSS terminated the contract.(30)

Fourth, some physicians received "provisional" contracts from the MDSS. These physicians argued that the MDSS did not follow a set of guidelines to determine which physicians received provisional contracts. The affected plaintiff physicians asked the MDSS for justification of the provisional contracts, but the MDSS did not respond. However, they did inform the provisional contract physicians that "if they refused to accept the provisional terms, their participation in the Medicaid program [would] be terminated."(31)

Fifth, several specialists among the plaintiffs were concerned about losing their Medicaid clients and not having the ability to replenish their caseload through the PPSP referral system. For example, a specialist new to the area would not have an established referral base. One plaintiff, a dermatologist with 80 percent of his caseload in the form of walk-in patients, argued that PPSP would drastically reduce his Medicaid caseload (65 percent of his practice) and would, most likely, force him to move his practice out of any area with a high Medicaid population.(32)

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30. Ibid., pp. 3, 13, and 17.

31. Ibid., p. 4.

32. Ibid., p. 6.

On October 5, 1982, the Court dissolved the restraining order and ordered the MDSS to change the PPSP contract in two ways. First, the limit on enrollees per sponsor physician was raised to 2,000. Second, the MDSS could not terminate a PPSP contract without first giving the sponsor the opportunity for peer review and an administrative hearing.(33) The MDSS complied with the Court's order and rewrote relevant sections of the sponsor contract.

Court intervention seems to have affected the implementation of PPSP, in general, and marketing to physicians, in particular, in three ways. First, the TRO strengthened the legal basis of PPSP. The plan had been tested in Court and passed without significant changes. This foundation made it more difficult for those who might challenge PPSP in the future. In addition, the strengthened legal basis of PPSP could be used as a selling point to physicians and recipients.

Second, the TRO slowed the pace and almost suspended the implementation of PPSP. As a result, the PPSP lost some momentum and status as a newly implemented program within the MDSS. For example, the high priority which the PPSP initially enjoyed with the MDSS computer systems was forfeited during the TRO. After the TRO was lifted, it was more difficult for the PPSP to regain its high priority status.(34) This caused delay in the planned implementation schedule. The MDSS had hoped to complete physician and recipient enrollment within one year.

Finally, the TRO slow-down had the positive effect of giving the MDSS and the Steering Committee some time to respond to implementation issues that had arisen. For example, different marketing strategies could be considered for physicians who provided care to Medicaid recipients and those who did not.

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33. Vicki Belin, Nadine Miller, et al., vs. Noble Kheder, Michigan Department of Social Services, "Opinion of the Court," Civil Action Case No. 82-225, 143-CK, In The Circuit Court For The County Of Wayne, State of Michigan, October 5, 1982.

34. Project Director, Bureau of Program Policy, Medical Services Administration, Technical Advisory Panel Presentation, November, 1984.

1.6 CONCLUSION

In contrast to many other states' primary care case management initiatives, PPSP development involved a great deal of provider and recipient input and scrutiny. While this involvement was time-consuming and, at times, difficult to contain, it did help iron out many problems before PPSP was set in motion. At implementation, the PPSP design was the most comprehensive and detailed case management program plan in place. In spite of all this preparation, however, PPSP remained a controversial program, especially among many Medicaid physicians.

CHAPTER 2:

OBJECTIVES, DUTIES, AND RESPONSIBILITIES UNDER PPSP

2.1 OBJECTIVES

As noted above, there are four main objectives for the PPSP:(35)

(1) Contain Medicaid costs while paying equitable fees to physicians.

(2) Improve recipients' access to mainstream medical care.

(3) Increase primary care physician participation in Medicaid.

(4) Better manage recipient use of medical services.

This section describes these four expected results more fully, particularly the criteria that define success in accomplishing each objective. The remainder of the chapter documents the PPSP duties and responsibilities of MPSS, physicians, recipients and the oversight committees.

A. Contain Costs

Assuming eventual enrollment of a targeted 286,448 non-institutionalized AFDC and SSI recipients in Wayne County (see Chapter 4, Section 4.2), the MDSS expected implementation of PPSP to generate net savings of about $19.7 million per year. This figure was based on MDSS 1982-83 utilization and cost data.(36) Approximate net savings per recipient were expected to be about $69 per year. The net savings were the difference between projected gross savings of $38.5 million and additional costs of $18.8 million. For PPSP, then, net savings were

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35. Director, Division of Planning and Evaluation, memo to the Monitoring and Evaluation Subcommittee of the PPSP Steering Committee, September 8, 1982; Michigan Department of Social Services, interviews.

36. Office of Research and Demonstrations, Health Care Financing Administration, "The Medicare and Medicaid Data Book," Health Care Financing Program Statistics, April, 1982; Planning and Evaluation Division, Office of Planning, Budget, and Evaluation, Michigan Department of Social Services, Health Care Alternatives Within Title XIX Demonstration Project Fourth Quarter Progress Report, June, 1984, pp. 64-67.

projected at about 51 percent of gross savings. The components of estimated gross savings and additional cost are shown in Exhibit 2.1.(37) Given the lower than expected enrollment in PPSP during the first 26 months of implementation (only 54,000 of a targeted 286,000 recipients had enrolled by September, 1984), these cost savings estimates were very optimistic.

More details on the projected change in utilization of services and expenditures under PPSP are shown in Exhibit 2.2.(38) The savings and utilization tables are predicated on an MDSS analysis of the service patterns of all 126,703 continuously eligible Wayne County recipients for the period of April, 1982, to March, 1983. Since this continuously eligible group was about 44 percent of the total number expected to join PPSP (286,448), the amounts shown in the exhibit were increased by a factor of 2.26 to estimate the effect of enrolling the total PPSP target population. We based this calculation on the assumption that the other 159,745 recipients' 1982-83 utilization and cost patterns were similar to those of the continuously eligible and that their PPSP additional costs would be similar.

The PPSP was expected to generate these savings by influencing the use of in-patient hospital care, doctor visits, emergency room visits, prescription drugs, and laboratory procedures. As shown in Exhibit 2.1, the implementation of PPSP was expected to affect nine categories of expenditure. The largest change, a $26.8 million decrease (70 percent of estimated gross savings) was expected for in-patient hospital care. To achieve these savings, sponsor physicians were expected to decrease medical and surgical admissions by 15 and 10 percent, respectively. Part of the savings would be offset by an expected rise in hospital per diem reflecting the smaller number of Medicaid patients and an increase in outpatient visits for surgical procedures that were previously done on an inpatient basis. (See the lower pie chart in Exhibit 2.1 and the detailed MDSS analysis in Exhibit 2.2.)

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37. Planning and Evaluation Division, Office of Planning, Budget, and Evaluation, Michigan Department of Social Services, Health care Alternatives Within Title XIX Demonstration Project Fourth Quarter Progress Report, June, 1984, pp. 64-67.

38. Department Analyst, Bureau of Program Policy, Medical Services Administration, "Cost Benefit Analysis, PPSP, FY 1983/1984," February, 1984.

EXHIBIT 2.2

DETAILED UTILIZATION AND EXPENDITURE CHANGE PROJECTIONS*

4/1/82-3/31/83 Utilization & Cost	Expected Direction and % Change	Expected Expenditure Change
54,979 Hospital Admissions		
60% Medical = 32,987 40% Surgical = 21,992	x 15% Reduction = x 10% Reduction =	4,948 2,199
		7,147 Adm.
Average Cost/Stay = $3,750		x$ 3,750 Avg.
		-$26,801,250 Avg.
Remaining Stays = 47,833	x $157.50 increase =	+$7,533,698
2,199 Surgical Admissions Average OPH Visit = $200.00	x 40% increase =	+$175,920
		NET HOSPITAL SAVINGS:
		-$19,091,632 Savings
1,309,473 Doctor Visits Average Cost = 13.94/visit	x 20% reduction =	261,895 Dr. Visits
		x$ 13.94 Avg.
		-$ 3,650,812 Savings
5,844 clients used ER 3 or more times, totaling 23,414 ER visits. Average cost per ER Visit = $43.16	x 50% reduction =	11,707 ER Visits
		x$ 43.16 Avg.
		-$ 505,274 Savings

Use of prescribed drugs was expected to decline by $6.0 million, 16 percent of gross savings. These savings were expected from a general 20 percent decline in prescriptions for high users -- that is, those with more than 42 prescriptions per year -- and an additional reduction attributable to fewer office visits. An average of 1.99 prescriptions per visit was used to gauge the effect of fewer doctor visits.

Decreased physician office visits were the third largest projected gross savings. It was expected that the number of physician visits will decrease by 20 percent, accounting for about ten percent of gross savings or $3.7 million. Recipients would not be able to visit more than one physician without prior authorization (except in emergencies).

Decreases in the use of lab procedures and emergency rooms were expected to account for five percent of gross savings with utilization falling by 20 percent and 50 percent, respectively. Savings of $1.5 million and $0.5 million would be generated.

The lower half of Exhibit 2.1 outlines the additional costs that were expected from PPSP operation. In addition to increased hospital per diem and outpatient visits (discussed above), the PPSP would require expenditures for case management fees and additional administrative costs. Assuming the maximum in case management fee costs -- that is, $3.00 per month for 12 months for all 286,448 enrollees -- case management expenditures would be about $10.3 million, more than half the additional costs of the PPSP. Administrative costs of $0.8 million per year were expected to cover PPSP administration at the county level and computer processing services.

B. Improve Access to Mainstream Medical Care

One rough indication of improved access would be an actual decrease in the number of recipients who do not receive any medical services in a year. An estimated 25 percent of Wayne County Medicaid enrollees fell into this category,

EXHIBIT 2.2, CONTINUED

13,180 recipients had more than 42 prescriptions, totaling 994,009 prescriptions.	x 20% reduction	=	198,802	Prescript'ns
Average cost per prescription = $8.31			x $8.31	Avg.
			-$1,652,043	
261,896 Reduced Doctor visits	x 1.99 decrease	=	521,173	Prescript'ns
			x $8.31	Avg.
			-$4,330,948	
			TOTAL PRESCRIPTION SAVINGS:	
			-$5,982,991	Savings
1,143,103 Laboratory Procedures	x 20% reduction	=	228,621	Lab. Proc's
Average Cost per Laboratory Procedure is $6.50.			x $6.50	Avg.
			-$1,486,034	Savings

*Based on MDSS 1982-83 statistics for a population of 126,703 recipients continously enrolled for one year, multiplied by 2.26 to account for the entire PPSP target population in Wayne County. No adjustment for differences in utilization and expenditure associated with non-continuous Medicaid enrollment have been made.

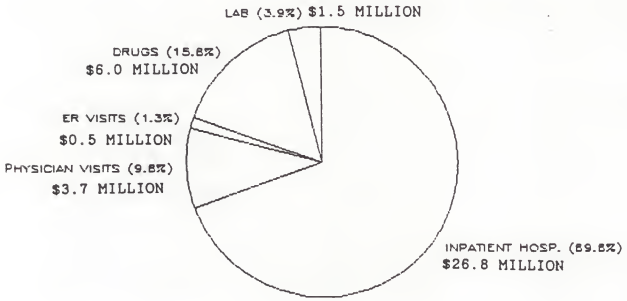
Source: Planning and Evaluation Division, Office of Planning, Budget, and Evaluation, Michigan Department of Social Services, Health Care Alternatives Within Title XIX Demonstration Project Fourth Quarter Progress Report, June, 1984, pp. 64-67.

EXHIBIT 2.1

PROJECTED COST IMPACT OF PPSP

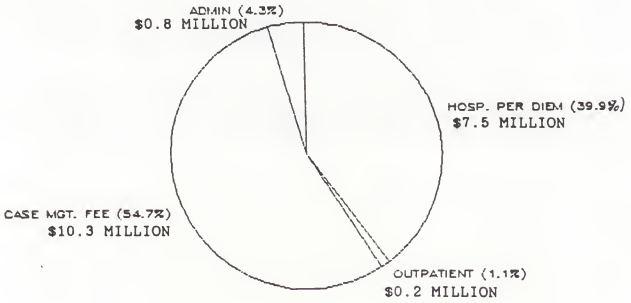
COMPONENTS OF GROSS SAVINGS

TOTAL GROSS SAVINGS: $38.5 MILLION



COMPONENTS OF ADDITIONAL COST

TOTAL ADDITIONAL COST: $18.8 MILLION



so a decrease in this percentage might signal improved access.(39)

Some Medicaid recipients did not have good access to primary medical care because they lacked an established regular relationship with a primary care physician. For example, the NCHR's National Health Care Expenditure Study (NHCES) shows that just over 52 percent of the Medicaid enrollees polled in 1983 considered the physician's office to be their usual source of care. Of the remainder, the largest group, 15 percent, had no usual source of care; equal proportions, about 10 percent each, used health centers or hospital outpatient departments; and 2.3 percent reported using emergency rooms.(40) Despite differences in the usual source of care, another survey conducted as part of the California Prepaid Health Research Evaluation and Development Project (PHRED) showed that 78 percent of Medicaid recipients reported having a "regular doctor." This figure, when compared to the NCHES's 52 percent who usually went to a physician's office, suggests that about one-quarter of Medicaid enrollees have a regular doctor who practices outside the physician's office setting. This is in addition to the 22 percent who do not have a regular doctor.(41)

The absence of an established relationship with a primary care physician is more likely among Medicaid recipients who reside in underserved areas, i.e., places where there is a shortage of physicians in general or primary care physicians in particular. Regardless of the reason, recipients without an established relationship with a primary care physician would seem more likely to miss needed medical care and preventive health care. They may experience dif-

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39. Planning and Evaluation Division, Office of Planning, Budget, and Evaluation, Michigan Department of Social Services, Health Care Alternatives Within Title XIX Demonstration Project Fourth Quarter Progress Report, June, 1984, p. 82.

40. Gail R. Wilensky, and Amy Bernstein, "Contacts with Physicians in Ambulatory Settings: Rate of Use, Expenditures, and Sources of Payment," NCHSR National Health Care. Expenditure Study (Data Preview 16), Washington, D.C., Department of Health and Human Services, 1983. In Planning and Evaluation Division, Office of Planning, Budget, and Evaluation, Michigan Department of Social Services, Health Care Alternatives Within Title XIX Demonstration Project Fourth Quarter Progress Report, June, 1984.

41. Planning and Evaluation Division, Office of Planning, Budget, and Evaluation, Michigan Department of Social Services, Health Care Alternatives Within Title XIX Demonstration Project Fourth Quarter Progress Report, June, 1984, p.

ficulty and delay receiving appropriate medical services and seem less likely to receive clear and consistent medical advice because of the number and variety of health professionals they encounter.

Through PPSP's addition of primary care physicians, patient-assignment, prior authorization and other provisions that center management of a patient's care with a single physician, it was expected that some enrollees would experience better access to mainstream medical care. There are several ways that improved access to medical care would be evident. For PPSP, it was expected that recipients' perceptions of the availability and ease of receiving care would be a key indicator. The following specific changes were expected:

- o increased reported satisfaction with access including such factors as decreased avoidance of care
- o decreased distance and travel time to physician's office
- o decreased appointment wait
- o decreased length of time in physician's waiting room and
- o increased reported satisfaction with access to consultation and services outside regular office hours, including second opinions and emergency services.

In addition, it was expected that decreased use of multiple physicians (doctor shopping) would occur in conjunction with improving access. Finally, there was a general expectation that the quality of medical care would improve as a result of better access through PPSP. This would be indicated, for example, by lower infant mortality and decreased deaths related to prescription drugs.

C. Increase Physician Participation in Medicaid

Increasing physician participation means gaining sponsor contracts with more Wayne County primary care physicians than were participating in Medicaid before PPSP. This implies both retaining those who were already serving under Medicaid and attracting those who did not participate before, especially primary care specialists. Physicians were expected to be attracted to PPSP because of

advantages like the case management fee and a better opportunity to manage enrolled recipients' total health care. These incentives were expected to counteract traditional reasons for many physicians choosing not to participate in Medicaid. As a result, the number of primary care physicians located in underserved Medicaid client zip code areas might increase. This could occur because established Medicaid primary care physicians would open offices in these areas or because physicians already located there would decide to sign sponsor contracts.

The average size of Medicaid caseloads was expected to be affected by the increase in available primary care physicians. Overall, there was expected to be a higher percentage of physicians with fewer than 500 recipients. This would be followed by a decrease in the variation in the average number and cost of services per recipient for comparable Medicaid caseloads. Since average cost per recipient relates to better managed care, the discussion of this change is continued below.

D. Improve Management of Care for Recipients

As a result of their efforts in seeking care or the actions of their physicians, some recipients use an inordinate amount of medical services. This shows up in the patterns of service and expenditures when recipients are compared. Over-users are, by definition, those individuals who exceed the range of normal use of services. In some cases, "over-use" signals misuse of Medicaid; in other cases, it means simply that the individual required an especially high level of medical care during the period of the comparison. Better management of the use of medical services means decreasing the number of recipients inappropriately using high amounts of service and decreasing the level of overuse in instances when it occurs.

Another equally important dimension of better managed use of services is financial control. Under PPSP, physicians were expected to manage costs better by exercising prudent judgment about such medical services options as inpatient versus out-patient surgery. According to the sponsor contract, providers with average per-recipient costs that exceeded the 95th percentile for all sponsors

with similar caseloads (size and type) would be penalized.

Improvements on these two indicators -- decreasing the percent of recipients who greatly exceed normal use of Medicaid and decreasing the percent of physicians whose average cost per PPSP enrollee is excessive -- defined achievement of the "better managed use of services" objective.

2.2 DUTIES OF THE MDSS

The Michigan Department of Social Services (MDSS) is the "administering agency" for Medicaid and PPSP. The point of focus for implementing PPSP is the Medical Services Administration (MSA). This agency of the MDSS is responsible in general for administering Medicaid and the PPSP, including day-to-day program and financial operations. The very complex structure of multi-organizational involvement in PPSP is depicted in Exhibit 2.3.(42)

The MSA has a broad range of Medicaid responsibilities including claims reimbursement, policy development, utilization review, fraud and abuse detection, rate setting for providers, institutional audits, third-party liability, budget preparation, and record-keeping. As lead agency for PPSP, MSA has responsibility for program design and implementation, day-to-day operations, and management and administration.

The PPSP Section and the Sponsor Specialist Office are the MSA units that concentrate the highest day-to-day effort and share of resources on PPSP. During the initial stages of PPSP, the Sponsor Specialist Office, which is located in Detroit, was the key contact point for recipients and providers; its primary duty was to enroll recipients. In March, 1984, there was a transfer of the clerical "paper processing" tasks associated with recipient enrollment from that office in Detroit to the PPSP Section in Lansing. The Detroit Sponsor Specialist Office has since operated as a PPSP recipient and provider problem-solving unit.

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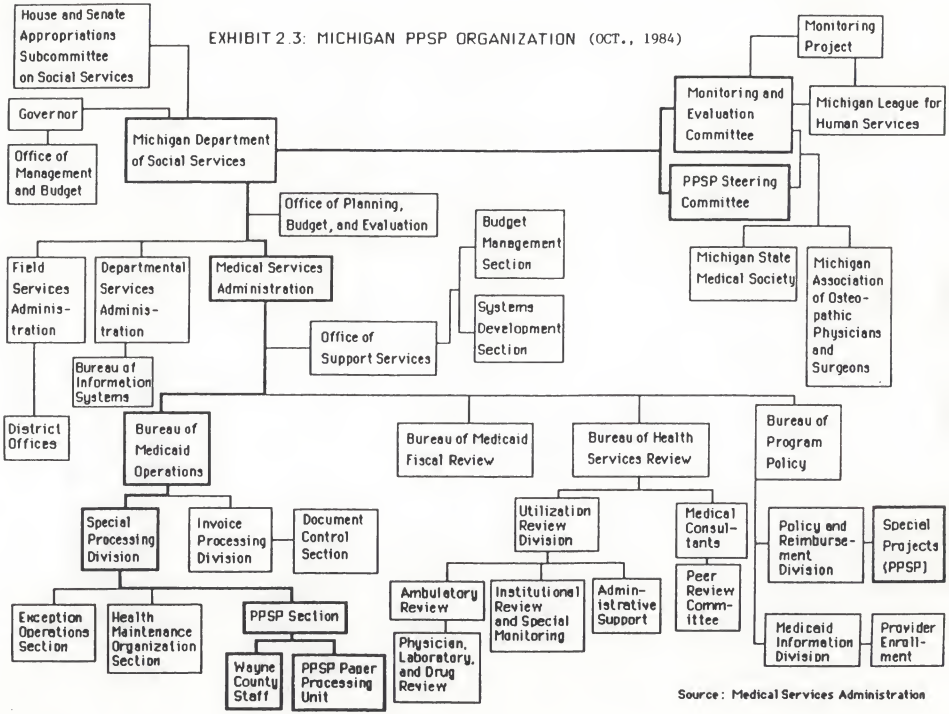
42. Medical Services Administration, Michigan Department of Social Services, Organization Charts, 1984-5; site visit, May, 1985.

EXHIBIT 2.3: MICHIGAN PPSP ORGANIZATION (OCT., 1984)



Source: Medical Services Administration

While day-to-day responsibility belongs to the MSA, policy decision-making authority for PPSP rests with the Director of MDSS. Currently, the Monitoring and Evaluation Committee, a broadly-based advisory group, is the primary source of policy recommendations. Previously, the PPSP Steering Committee, a group representing MDSS, the legislature, and physician organizations, was the main source of policy direction. The remainder of this secton focuses on MSA's direct PPSP administrative responsibilities while the last section of this chapter addresses the oversight committees.

The MSA responsibility for continuing administration of PPSP includes the six functions described below. While there are other general MSA duties involved in the administration of PPSP only the duties unique to PPSP are summarized here.

A. Pay $3.00 Case Management Fee

The MSA is required to pay sponsors a three-dollar case management fee per month for every recipient enrolled in their caseload. Total case management fees for a single sponsor may not exceed $3000 per month. Predicated on 286,448 enrollees, the original PPSP target for Wayne County, the total maximum fee would be $10,312,128 annually.

The MSA uses several reports to verify accurate case management fee payment to sponsors. The FM-085 and the gross adjustment report (FM-092) provides sponsors with the monthly sum.(43) The MSA also generates in-house reports directly from the MDSS Client Information System for case management fee verification (FM-091).(44)

B. Set and Monitor Cost-Effectiveness Standards

The MSA must calculate and enforce cost-effectiveness standards for sponsors. As set out in part one in Addendum A of the sponsor contract, the "95th

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43. FM-092, Gross Adjustment Report.

44. FM-091, Management Fee Report.

percentile," refers to those physicians whose average cost per recipient lies in the top five percent for all like physicians and patients. Sponsors are stratified according to the number and type of recipients in their caseload. After adjustments for caseload size, sponsors must fall within the 95th percentile of average cost per recipient for the following services provided personally or through referrals: in-patient hospital, out-patient hospital, physician, laboratory, radiology, and pharmacy services. When this standard is not met, the MSA may follow through with a warning, withholding the case management fee for a probationary period, or terminating the contract. These sanctions are to be enforced by the peer review committee and the state.(45)

While this authority to monitor and sanction physicians for excessive utilization exists, the MSA has never implemented it. As late as mid-1986, the MSA was still discussing the need to develop and use cost-effectiveness standards for PPSP sponsor physicians.

C. Provide Necessary Reports to Sponsors

In addition to reports that assure accurate case management fee payments (see above), the contract requires MSA to provide sponsors with utilization and cost reports for those enrolled recipients who "exhibit unusual utilization patterns." The utilization report (FM-140) details health service utilization patterns for high use recipients.(46) The report compares use of services (physician, pharmaceutical, hospital, etc.) over four quarters. Sponsors may request an additional report, the claims detail report (FJ-461), which provides the specific provider and service given to the PPSP enrollee during one quarter.(47)

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45. Michigan Department of Social Services, Medical Assistance Plan, "Physician Primary Sponsor Plan Contract," October 1, 1984. (See Attachment 1.2).

46. FM-140, Quarterly Report of Services Rendered to PPSP Enrollees.

47. FJ-461, Recipient Claims Listing, Detail Report.

In addition, the MSA used to send each sponsor a monthly report of PPSP enrollees' names added to or deleted from their caseload (FM-081).(48) Now, the MSA sends each sponsor a monthly list of the PPSP enrollees in their caseload (FM-085).(49) Included on this list is each recipient's ID number and date of enrollment.

D. Enroll (and Disenroll) Recipients

From July, 1982, until March, 1984, the MSA had direct responsibility for enrolling recipients into PPSP. This included responsibility for identifying and contacting recipients to be recruited, processing enrollment applications, and maintaining enrollment and utilization records.

Since March, 1984, the MSA has had less direct responsibility for enrolling recipients into PPSP. Under revised procedures, recipients may forward an enrollment application in response to MSA information bulletins or the urging of their physician (if the physician is also a sponsor) or they may be recruited by their social services caseworker. The caseworker-initiated enrollment effort at intake or annual eligibility redetermination involves requiring recipients to fill out an enrollment form if they have not completed one before. However, in lieu of actually filling out this form, a recipient may note refusal to enroll in PPSP or any other delivery plan. Although direct involvement is reduced, the MSA oversees the revised enrollment approaches.(50)

The terms of the enrollment and participation agreement include the recipient's right to change provider or disenroll from PPSP or another plan. (An MSA flowchart for PPSP and HMO disenrollment procedures is presented in Exhibit 2.4.) Prior to filing a request to disenroll, the recipient is urged to discuss any problems with his or her provider. If the cause for disenrollment persists, the recipient is then asked to review the problem with a Sponsor

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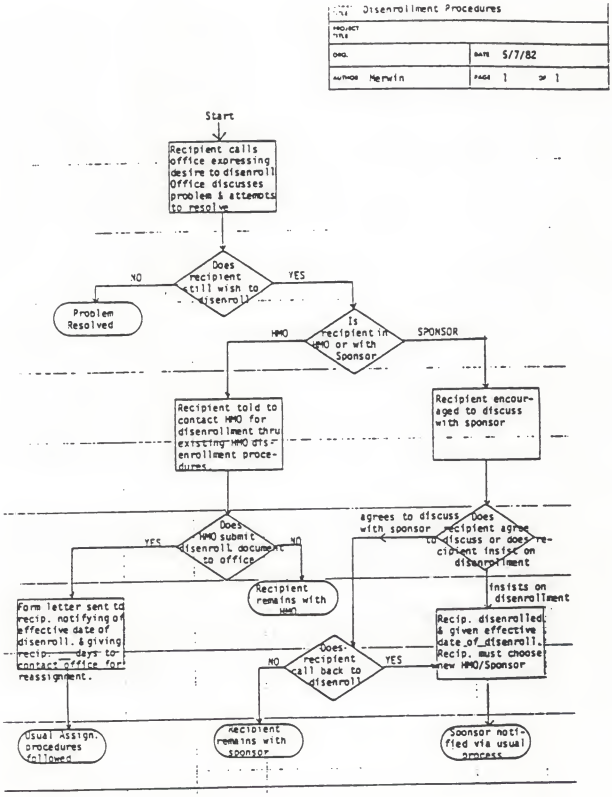
48. FM-081, Recipient Enrollment List.

49. FM-085, Monthly Listing of Enrollees Per Sponsor.

50. Attachment 2.1 (PPSP Caseworker Seminar) provides details of MSA's training for caseworkers in PPSP procedures, including enrollment.

Exhibit 2.4

PPSP DISENROLLMENT FLOWCHART


Disenrollment Procedures
PROJECT TITLE
ORG.
DATE 5/7/82
AUTHOR Merwin
PAGE 1 OF 1
Start
Recipient calls office expressing desire to disenroll. Office discusses problem & attempts to resolve
Does recipient still wish to disenroll
NO
YES
Problem Resolved
Is recipient in HMO or with Sponsor
HMO
SPONSOR
Recipient told to contact HMO for disenrollment thru existing HMO disenrollment procedures.
Recipient encouraged to discuss with sponsor
Does HMO submit disenroll document to office
YES
NO
Recipient remains with HMO
Does recipient agree to discuss or does recipient insist on disenrollment
agrees to discuss with sponsor
insists on disenrollment
Form letter sent to recip. notifying of effective date of disenroll. & giving recip. ___ days to contact office for reassignment.
Recip. disenrolled & given effective date of disenroll. Recip. must choose new HMO/Sponsor
Does recipient call back to disenroll
NO
YES
Usual Assign. procedures followed
Recipient remains with sponsor
Sponsor notified via usual process

Specialist. If the problem is still not resolved the recipient may disenroll and then must select a different sponsor, HMO, or CAP, but may not return to fee-for-service.

E. Sign Up Sponsors

The physician organizations share in the effort to market and recruit physician sponsors, but the direct responsibility to contract physicians rests with MSA. It is the MSA's responsibility to send a sponsor contract to every physician who applies. According to the original PPSP design, before the contract is sent, MSA is supposed to generate a worksheet according to part two of Addendum A of the sponsor contract. The worksheet summarizes information on the medical care delivery patterns of the physician applying for a contract. Sponsors are to be divided into two groups, depending on their delivery patterns, and the MSA is to notify the sponsors who are potential over-spenders, with a warning that their delivery patterns will be analyzed periodically.(51) At the time of the case study, analysis of care delivery patterns and notification of future analysis had not yet been implemented.

In addition, the MSA is directly responsible for trying to enroll non-sponsor physicians who have been requested by recipients wanting to enroll in PPSP.(52) These non-sponsor physicians are particularly important because their non-participation in PPSP slows implementation and helps delay potential benefits. The MSA has been marketing PPSP to non-sponsors requested by recipients since February, 1983.(53) (For an explanation of what happens to recipients who request non-sponsor physicians, see Chapter 4.)

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51. FK-095 Analysis Sheet, Physician Sponsor Applicant; Physician Sponsoring Plan Monitoring Data, Level I, II, III Criteria; FK-095, Summary Profile Report Provider; Assistant Director, Medical Service Administration, Michigan Department of Social Services, "on notice" letter to sponsors.

52. Medical Services Administration, cover letter to sponsor contract to potential sponsors, June 1982; Michigan Department of Social Services, "Physician Primary Sponsor Plan Quality Care for Medicaid Recipients," March, 1983.

53. Monitoring and Evaluation Committee, "Minutes," April 22, 1983; "Minutes," June 3, 1983; "Minutes," August 15, 1983.

F. Ensure Necessary Administrative Resources

As lead agency for Medicaid and PPSP, the MDSS is implicitly responsible for ensuring that sufficient administrative resources are available to implement and maintain the special functions (procedures) associated with PPSP. This includes the provision of staff, computer resources and other needed services.

2.3 DUTIES OF PHYSICIAN SPONSORS

Sponsors have four key responsibilities under the PPSP contract. They are summarized here as follows:

A. Accept Patient Assignment

Sponsors are required to accept recipients as assigned by the MSA or the Medicaid Sponsor Office. The MSMS believes that patient-assignment is a crucial element of primary care cost containment under Medicaid. During PPSP planning the MSMS argued that controlling the patient is more critical than controlling the money, hence their position against financial risk-sharing and in favor of patient-assignment.

As noted in Chapter 3, a Wayne State University survey of Wayne County physicians showed that patient-assignment was one of PPSP's most attractive features. Physicians supported the concept of patient-assignment to a single sponsor with the argument that this would ensure comprehensive knowledge of their patients' medical care.

B. Accept Role as Case Manager

One of the themes of the sponsor contract is the sponsor's responsibility to assume the role of case manager. The contract specifies a variety of case manager duties. The most basic responsibilities are prior authorization, assuring medical care availability 24 hours a day, and rendering at least 50 percent of care.

Prior Authorization and Referrals. Physician sponsors are required to "prior authorize" most non-emergency medical care not provided by them or their immediate staffs. This includes specialist, X-ray, laboratory, and in-patient and out-patient hospital care. In addition, drug prescriptions must be authorized by the sponsor, unless a specialist to whom the enrollee is referred writes the prescription.

When referring a PPSP enrollee to another physician for medical care, the sponsor must:

- o authorize the referral care by contacting the specialist. (No special authorization form is required.) The authorization is for the duration of the recipient's illness as determined by the sponsor and the specialist. If the recipient has a chronic condition which requires continuing specialty care, the authorization may cover a longer period.
- o forward all applicable medical information (e.g., laboratory or radiology test results) to the specialist.
- o provide to the specialist his/her Medicaid ID Number for the practice location where the recipient is enrolled. The specialist must enter the sponsor's Medicaid ID Number as the referring physician on the Medicaid claim.
- o document that be authorized the referral in the recipient's medical records."(54)

The physician to whom the PPSP enrollee has been referred has the authority to "order most medical treatment for the recipient without the sponsor's authorization." However, sponsor authorization must be obtained when any of the following occurs: another physician or home health agency becomes involved or the patient is referred for outpatient or inpatient hospital care. Upon obtaining authorization, the sponsor and the referred provider must document authorization in the recipient's medical record. This documentation is required for provision of all medical care, including non-emergency medical care, primary medical care, and urgent care.(55)

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54. Michigan Department of Social Services, Medical Assistance Program Bulletin, No. 5310-82-03, p. 3.

55. Ibid., pp. 2-4.

24-Hour Access/Emergency Care. The sponsor contract specifies that sponsor physicians will be available to PPSP enrollees 24 hours per day, seven days per week. Sponsors are asked to provide the MSA with a 24-hour access telephone number. Initially, some physicians gave their home telephone number, their office number, or a number which ran a recorded message telling patients to go to the emergency room in the case of any emergency. Faced with these differences among sponsors, the MSA decided to establish guidelines for the 24-hour access.

The MSA is very clear about acceptable 24-hour access telephone number arrangements:

> One phone number that is answered during office hours by the doctor's office staff and at other times by (a) an answering service which can contact the doctor or another medical practitioner whom the doctor has designated to consult with the recipient during the sponsor's absence; (b) a recording directing the recipient to call another number to reach the doctor or another medical practitioner whom the doctor has designated; and (c) automatically transferring calls to another location where someone will answer the phone and be able to contact the sponsor or another medical practitioner who has been designated by the sponsor to treat the sponsor's patients.(56)

The MSA has been equally clear about the unacceptable arrangements for 24-hour access telephone numbers. Their guidelines identify the following as unacceptable:

- Using the doctor's home phone number as the 24-hour access number unless someone is there to answer that phone at all times.
- An office phone that is not answered except during office hours.
- An office phone which is answered after hours by a tape which tells recipients either to call back during office hours or to go to a hospital emergency room if they need care.
- Two phone numbers, one for days and one for nights.
- An office phone that refers the recipient to the doctor's home phone number during off-duty hours, unless an answering service takes calls when the doctor's home phone is not answered.
- An office phone which is answered after hours by a tape machine which directs the recipient to leave his or her name and phone number and informs the recipient that someone will return the call.

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56. Michigan Department of Social Services, 24-hour access letter to sponsors.

According to the PPSP's waiver requirements, PPSP must provide access to care for all emergencies. The contract distinguishes between two types of emergencies with respect to emergency service authorization: If there is a medical emergency, where "delay in treatment may result in the recipient's death or the permanent impairment of the recipient's health," then a hospital emergency room need not obtain the physician sponsor's prior authorization. If urgent care is needed, then the recipient and/or hospital emergency room must try to obtain the sponsor's prior authorization. The need for urgent care exists when the condition will not "cause death or lasting harm, but treatment should not wait for normal service." If the sponsor cannot be reached, then medical care may be rendered. Sponsor authorization should be obtained during the next service day.(57)

Render at Least 50 Percent Care. According to the sponsor contract, a PPSP physician must render at least 50 percent of the primary care provided to enrolled Medicaid recipients:

> An acceptable standard for the purpose of this paragraph shall be that the sponsor shall personally render at least 50 percent of the primary care physician procedures billed under the medical assistance program. Any primary care provided by physician assistants, nurse practitioners, or similar staff who are directly supervised by the sponsor shall be considered as personally rendered by the sponsor for the purposes of this paragraph.(58)

The 50 percent provision was included in the contract at the request of the MAOPS, who were concerned about physicians in out-patient clinics participating in PPSP. Because patients in these clinics are rarely associated with only one physician, the case manager role of the sponsor could be compromised in this setting.(59)

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57. Michigan Department of Social Services, Medical Services Administration, "Physician Primary Sponsor Plan Contract," June, 1982; amended October, 1984. (See Attachment 1.2).

58. Medical Services Administration, Michigan Department of Social Services, "PPSP Sponsor Contract," August 19, 1983, p. 3.

59. Project Director, Bureau of Program Policy, telephone interview, September, 1984.

C. Operate Cost-Effectively

In signing the contract, sponsor physicians agree to certain financial management conditions. The sponsors are not financially at risk for PPSP recipient medical costs. If the costs are unjustifiably high, the sponsor should try to decrease those costs, but is not financially responsible for any of the enrollees' medical assistance costs. Instead, sponsors must "review and act upon reports provided by the department pertaining to medical costs incurred by recipients enrolled with the sponsor." Sponsors are obliged to review reports on services rendered, note errors and report them to MDSS. If a recipient changes sponsors, the previous sponsor is required to transfer the recipient's medical records.

In essence, the sponsors must provide services in a cost-effective manner. The MDSS calculates specific over-utilization threshholds and applies them to the recent utilization pattern of each physician who applies to be a sponsor. The over-utilization thresholds for office visits and most medical procedures, which are found in the contract's "Addendum A", are set at two times that of the calculated average for physicians with like patient mix and caseloads. The over-utilization thresholds for diagnostic radiology procedures and pathology procedures per patient are set at three and four times, respectively, that of the calculated average. If a physician is found to have exceeded one or more of the ten service over-utilization thresholds in a given recent quarter, then specific cost threshholds are applied to that physician's average payment per patient or services. If any of these thresholds are exceeded, the physician is placed on provisional status as a sponsor.(60)

Similarly, there are utilization standards that apply after the sponsor begins serving under PPSP. If a sponsor is found to exceed these standards, basically the 95th percentile for all sponsors with similar caseloads, the MDSS, upon review by a peer review advisory committee, may take action against the sponsor.

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60. Michigan Department of Social Services, Medical Services Administration, "Physician Primary Sponsor Plan Contract," Addendum A, June 1982; October, 1984. (See Attachment 1.2).

D. Accept MDSS Actions

Upon signing the contract, the sponsor must accept MDSS actions which may be applied should the sponsor fail to fulfill the terms of agreement. In response to non-fulfillment of responsibilities, the MDSS may either refuse to pay case management fees during the relevant months, or suspend or terminate the sponsor contract.

However, sponsors may appeal MDSS actions through existing administrative channels. Physicians with PPSP-specific concerns are encouraged first to contact the PPSP Project Director in order to resolve difficulties that could lead to MDSS action or appeal of an MSA action.(61)

2.4 DUTIES OF RECIPIENTS

The MDSS did not develop a codified recipient agreement similar to the sponsor contract. Instead, the terms of the "Recipient Agreement" are communicated to recipients during enrollment and in information sent to recipients about PPSP. Since the program started in July, 1982, the following, mostly written, communications were developed and sent:

(1) "Medicaid Sponsor Plan," DSS-524 (6/82-2/84);

(2) "You Are Enrolled with a Doctor Under the Medicaid Sponsor Plan," DSS-534 (3/84-present);

(3) Recipient-initiated enrollment information: DSS-1111-37, cover letter, DSS-1336 (3/84-present);

(4) Physician-initiated enrollment information: "Medicaid Sponsor Plan, You Can Enroll as my Patient," DSS-418 (3/84-present);

(5) PPSP Information sheet, Medical Services Administration (3/84-present);

(6) "Your Rights and Responsibilities Under the Michigan Medicaid Program," Medical Services Administration, (10/83-present);

(7) Tel-Med Tape, PPSP Recipient (10/84-present); and

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61. Michigan Department of Social Services, Medical Services Administration, "Physician Primary Sponsor Plan Contract," June, 1982; October, 1984.

(8) "Select Your Plan for Health Care: Medicaid Sponsor Plans, HMO, Clinic Plan, DSS Publication 557 (7-84-present).

These communications, copies of which are provided in Attachment 2.2, were expected to make enrollees aware of their responsibilities under PPSP. Specifically, three main duties are emphasized: accept assignment, obtain care only from sponsors, and adhere to emergency care procedures.

A. Accept Physician Assignment

Recipients who were contacted from June, 1982, until February, 1984, received the following message:

> When you get this booklet, you must choose a DOCTOR or an HMO. You have 15 days to call the Medicaid sponsor number with your choice. If you do not call within 15 days, Medicaid will assign you to a DOCTOR or an HMO. The name and telephone number of the DOCTOR or HMO will be printed on your Medicaid Card. If you are not happy with the DOCTOR or HMO assigned to you, call the Medicaid sponsor number.(62)

During this period, the MDSS first gave recipients the opportunity to select their own sponsor before making a unilateral assignment. After March, 1984, unilateral assignments occurred infrequently.

The agreement to accept physician assignment has always included a provision defining the recipient's right to change sponsors or disenroll from PPSP. The following is from the Medicaid Sponsor Plan brochure.(63)

> IF YOU ARE NOT HAPPY WITH YOUR MEDICAL CARE
>
> You may ask Medicaid to change your DOCTOR or HMO. BUT FIRST,
>
> - Talk to your DOCTOR or HMO about your medical care. Your DOCTOR or HMO needs to know how their treatment helps or doesn't help you.

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62. Michigan Department of Social Services, "Medicaid Sponsor Plan," DSS-524, June, 1982 through February, 1984.

63. Ibid.

- If you keep having problems (like you can't get in for care with your DOCTOR or HMO or you are not happy with your medical care) call the Medicaid sponsor number. We will help you solve the problem.

- You may also ask for another DOCTOR'S opinion about your care. Your DOCTOR or HMO must refer you for a second opinion.

Your DOCTOR or HMO cannot refuse to treat you because of your race, sex, religion, age, national origin, color, marital status, handicap, political beliefs, or sexual preference.

The recipient is urged to talk with his or her sponsor first, then telephone the Sponsor Specialist to pursue the disenrollment.

B. Obtain Care Only from Sponsor

A second element of the agreement is the recipient's obligation to obtain care from the assigned provider. Furthermore, in pre-enrollment communications, the recipient is instructed to accept the referrals made by the sponsor.(64) In the post-enrollment brochure, "You Are Enrolled with a Doctor Under the Medicaid Sponsor Plan," enrollees are informed that they may request, from their sponsor, a specialist or a second opinion.(65)

C. Adhere to Emergency Care Procedures

Through a variety of sources, recipients are made aware of the procedures which they must follow in order to obtain emergency care. The instructions are as follows:

> You should always try to call your DOCTOR or HMO first in any medical emergency. They must have 24-hour service. If they cannot treat you in the office, they will tell you where to go for treatment. If you cannot call because a delay would cause lasting harm or loss of life, go to the hospital emergency room. The hospital will call your DOCTOR or HMO.

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64. Ibid.

65. Michigan Department of Social Services, "You Are Enrolled With a Doctor Under the Medicaid Sponsor Plan," DSS-534, March, 1984, through the present.

These instructions are also provided in the Tel-Med Information tape which is accessible at any time by telephone.(66)

2.5 PPSP OVERSIGHT

The MDSS established two committees to monitor the activities of PPSP and recommend policy. The first, the PPSP Steering Committee, focuses on physician participation. The second the Monitoring and Evaluation Committee, focuses on recipient involvement in PPSP. The characteristics of each committee and the relationship between the two committees are depicted in Exhibit 2.5, "Oversight Committee Relationships and Membership." Representatives for providers, Medicaid enrollees, the MDSS, the MSA, and the State Legislature, participate on each committee. The presence of external oversight committees has meant that the MSA, which has PPSP administrative responsibility, has had to obtain agreement with one or both committees before changing PPSP policy.(67)

A. PPSP Steering Committee

In October 1981, the MSA established the PPSP Steering Committee, chaired by the Director of the MSA (Director of the MDSS in absentia). The first meeting of the Committee took place on October 29, 1981. Its initial assignment was to develop the sponsor contract. After completion of the contract, the Committee assumed responsibility for contract revisions. In addition, the Committee had ultimate authority regarding recommendations to the MDSS when PPSP was planned and during the first year of implementation.

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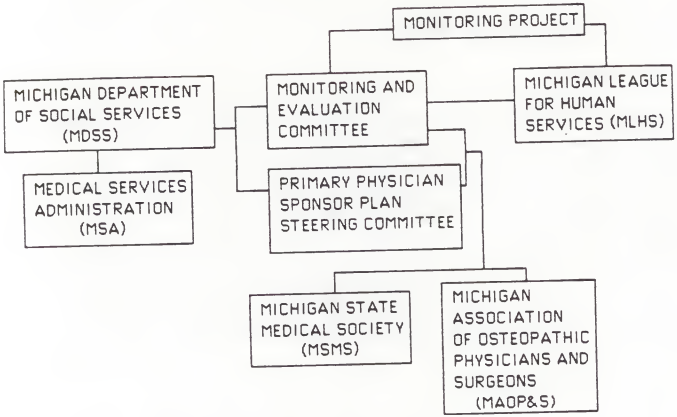
66. Michigan Department of Social Services, "Medicaid Sponsor Plan," DSS-524, June 1982 through February 1984; Michigan Department of Social Services, "You Are Enrolled With A Doctor Under the Medicaid Sponsor Plan," DSS-534, March, 1984, through the present; Medical Services Administration, Tel-Med Tape, PPSP Recipient, October, 1984, through the present.

67. Department Analyst, Bureau of Program Policy, Medical Services Administration, telephone interview, September, 1984.

EXHIBIT 2.5: OVERSIGHT COMMITTEE RELATIONSHIPS AND MEMBERSHIPS


MONITORING PROJECT
MICHIGAN DEPARTMENT OF SOCIAL SERVICES (MDSS)
MONITORING AND EVALUATION COMMITTEE
MICHIGAN LEAGUE FOR HUMAN SERVICES (MLHS)
MEDICAL SERVICES ADMINISTRATION (MSA)
PRIMARY PHYSICIAN SPONSOR PLAN STEERING COMMITTEE
MICHIGAN STATE MEDICAL SOCIETY (MSMS)
MICHIGAN ASSOCIATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS (MAOP&S)

	PRIMARY PHYSICIAN SPONSOR PLAN STEERING COMMITTEE	MONITORING AND EVALUATION COMMITTEE
ORIENTATION	Physician	Recipient
CHAIRPERSON	Director of MDSS Director of MSA (alternate)	Deputy Director of Legal Aid of Michigan
MEMBERSHIP	MDSS, MSA, MSMS, MAOP&S, legislative staff, physicians, welfare rights representatives	MSA, MDSS Office of Planning and Evaluation, Wayne County Department of Social Services, Health Maintenance Organization representatives, Medicaid recipients, advocacy groups, MSMS and MAOP&S

B. Monitoring and Evaluation Committee

Currently, the Monitoring and Evaluation Committee is the key source for recommendations on PPSP policy to the MDSS. In April, 1984, this recipient-oriented committee assumed the policy advisory role which had been held by the provider-oriented PPSP Steering Committee. The Monitoring and Evaluation Committee receives information from various sources, particularly the MSA and the MLHS. The latter is under contract to MDSS to collect and analyze data for the Committee. Its primary activity is to survey a random sample of recipients who have been enrolled in PPSP for about six weeks. Since May, 1984, the MLHS has been receiving the list of enrollees to be surveyed from the MSA's PPSP Unit. It is a list of recipients who have been enrolled in PPSP for at least six weeks. The PPSP Unit selects every tenth enrollment form from every twentieth page (approximately). By the time the selected enrollees receive the survey, about two percent of the enrollees have disenrolled and re-enrolled into an HMO. However, the survey explicitly requests that recipients describe their PPSP experiences.

In 1983, 100 questionnaires were mailed each month. In 1984, the number was reduced to 50. For 1985, the sample size was increased to 100 again. About 50 percent of these enrollees are resurveyed three or six months later.

In addition, the MLHS regularly contacts a small number of Wayne County sponsors, hospitals, clinics, and community groups (under ten of each) to determine their attitudes toward PPSP.(68) The MLHS developed an open-ended questionnaire which was sent to a small random sample of sponsors who received January, 1983, case management fees, and to the major welfare rights organizations and community groups in contact with PPSP-enrolled recipients. To supplement raw data collected through surveys during 1983 and 1984, the MLHS held monthly meetings with the Sponsor Specialist Staff in Wayne County and the MSA in Lansing to discuss issues in implementating the PPSP enrollment proce-

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68. Michigan League for Human Services, "Physician Primary Sponsor Plan Monitoring Project: Annual Report, September, 1983 - August, 1984," October 1, 1984, pp. 23-24.

dures.(69)

C. Participants' Complaints

Finally, there are several ways that participating recipients and sponsors can make known their problems and dissatisfaction under PPSP. The most basic for recipients is through contact with the Sponsor Specialists in Detroit, the PPSP Unit, the PPSP Project Director in Lansing, or their regular MDSS caseworker. Recipients also may seek assistance through state and local recipient advocacy groups. Physicians participating in PPSP have avenues of problem-solving similar to those of PPSP recipients.(70)

2.6 CONCLUSION

The PPSP's designers had high expectations for the program. Enrollment was targeted at 286,000, which was expected to yield one-year savings of over $19 million. In addition, PPSP was expected to improve access to medical care, increase physician participation in Medicaid, and improve case management.

To accomplish these objectives, the PPSP has required a great deal of adminstrative attention and the involvement of many units within and outside the Michigan Department of Social Services. In particular, the Medical Services Administration (MSA) has been responsible for much of PPSP's initial implementation and routine maintenance, including enrolling physicians and recipients, establishing and using cost-effectiveness standards, and producing utilization and cost reports. Physicians and recipients have several specific responsibilities under PPSP, too, and MSA has had to ensure that these are carried out as expected. In short, PPSP is a very complex program, both to set up and to administer. The importance of adequate resources cannot be overstated.

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69. Michigan League for Human Services, "Physician Primary Sponsor Plan Monitoring Project: Final Report," September 20, 1983.

70. Project Director, Bureau of Program Policy, Medical Services Administration, telephone interview, September, 1984; Chairperson, Monitoring and Evaluation Committee, telephone interview, April, 1985.

CHAPTER 3

RECRUITING PHYSICIANS

3.1 PHYSICIANS' PREDISPOSITION TOWARD MEDICAID

Some Medicaid enrollees may have a problem gaining access to desired medical services because of a shortage of physicians participating in Medicaid. One objective of PPSP is to attract more physicians into Medicaid, particularly those with practices oriented to primary care, including general practice, family practice, internal medicine, obstetrics and gynecology and general surgery. In simple terms, this means adding to the number of primary care physicians who are active in Medicaid. It is estimated that, before PPSP, 3116, or 58 percent, of the Wayne County primary care practitioners provided services under Medicaid.(71)

A 1984 survey indicated that physicians in Wayne County viewed Medicaid patients as: 1) less inclined to adhere to physicians' orders, 2) less likely to comply with medical office routines (e.g., appointment-keeping, promptness, etc.), 3) less likely to place emphasis on preventive medicine, and 4) less likely to maintain healthy lifestyles. Even further, the physicians viewed Medicaid patients as being more likely to overutilize medical services and medications -- particularly for minor illnesses and complaints. Exhibit 3.1 presents survey data on physician attitudes toward Medicaid patients.

Perhaps more important in determining willingness to join PPSP are the attitudes of physicians toward Medicaid. Exhibit 3.2 presents survey data from non-participating Wayne County physicians. Among the major reasons given for not participating in Michigan Medicaid were low fee payments, too much paper work, long delays in receiving payment, and low hospital fees. In addition, over 90 percent of the physicians felt that the attitudes of the Medicaid administrative staff toward physician providers and errors in program administra-

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71. This is an estimation calculated from MSMS and MAOPS estimates of the total number of MDs and DOs licensed in Wayne County. Telephone interviews, May, 1985. The estimated total of MDs and DOs in Wayne County is 5327.

EXHIBIT 3.1

PHYSICIAN COMPARISONS OF MEDICAID PATIENTS
TO OTHER TYPES OF PATIENTS

	Percentage Responses		
	Lower	No Difference	Higher
Overall medical need	5%	44%	51%
Adherence to physician orders	69	31	1
Compliance to office routine (appointment keeping, promptness, etc.)	79	19	3
Emphasis on preventive medicine	53	25	3
Maintenance of healthy life styles	87	11	2
Utilization of drugs	18	32	50
Utilization of medical services	9	30	61

Source: Goldberg, T., "Report on the Survey of Physicians in Wayne County, Michigan on their Attitudes Toward and Intention to Participate in the Michigan Medicaid Physician Primary Sponsor Plan (PPSP)," September 6, 1984.

EXHIBIT 3.2

PHYSICIANS' REASONS FOR NOT PARTICIPATING
IN THE MICHIGAN MEDICAID PROGRAM

Reason for not Participating	Percentage Responses			
	No Effect	Slightly Important	Important	Very/Extremely Important
Fee too low	9%	6%	29%	56%
Too much paper work	6	9	14	71
Long delays in payment	9	9	21	61
Attitudes and errors of Medicaid admin. staff	9	9	21	62
Low hospital fees	9	15	27	48
Characteristics of Medicaid patients	14	28	31	28
No wish to participate in a government sponsored program	54	18	14	15

Source: Goldberg, T., "Report on the Survey of Physicians in Wayne County, Michigan on their Attitudes Toward and Intention to Participate in the Michigan Medicaid Physician Primary Sponsor Plan (PPSP)," September 6, 1984.

tion also contributed to non-participation. Overall, it appears that generally negative attitudes on the part of physicians toward Medicaid patients and the Medicaid program may partially explain the unwillingness of some physicians to become PPSP sponsors.

3.2 INCENTIVES TO JOIN PPSP

Physicians in Wayne County were generally familiar with PPSP, but varied considerably in their expressed attitudes towards specific provisions of the plan. Ninety-eight percent of the physicians responding to the 1984 survey were aware of PPSP. Sixty-one percent were familiar with the specifics of PPSP (i.e., had seen a sponsor contract) and 25 percent were familiar with its basic concepts. Most had become aware through the MDSS/MSA (30 percent) or the Wayne County Medical Society (28 percent). The remainder learned about PPSP through the MAOPS, the Detroit Medical Society, the public media or from another source.(72)

While the number of surveyed physicians participating (or intending to participate) in PPSP was not presented in the analysis of survey results,(73) it was reported that 70 percent of this group were joining PPSP as primary sponsors in order to maintain their current Medicaid caseload. Several other specific provisions of the sponsor agreement were also important in explaining physicians' decisions to join PPSP. Exhibit 3.3 presents data on the relative importance of specific provisions of PPSP in physicians' enrollment decisions. About 70 percent reported that patient-assignment (lock-in) and case management fees were important to their decision; 60 percent viewed prior authorization of referrals as a factor. Less than 50 percent felt that MDSS monitoring of utilization, the possibility of expelling sponsors, or 24-hour access were important factors. There may be difficulty distinguishing between patient-assignment and prior authorization because prior authorization is one way that

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72. Goldberg, T. "Report on the Survey of Physicians in Wayne County, Michigan, on their Attitudes Towards and Intention to Participate in the Michigan Medicaid Primary Sponsor Plan (PPSP)," September 6, 1984.

73. The MDSS has requested this information.

EXHIBIT 3.3

PROVISIONS OF PPSP AFFECTING PHYSICIAN DECISIONS TO JOIN AS PRIMARY SPONSORS

PPSP Provisions	Percentage Responses			
	Did not Affect	Slightly Important	Important	Very/Extremely Important
Patient assignment and lock-in	30%	11%	38%	21%
Case management fee	31	23	31	15
Prior authorization of referrals	40	23	22	15
MDSS monitoring	56	17	21	6
MDSS criteria to expel physicians from plan	55	17	15	14
Twenty-four hour patient coverage	50	22	18	10
Number of Medicaid patients per sponsor	47	20	19	13

Source: Goldberg, T., "Report on the Survey of Physicians in Wayne County, Michigan on their Attitudes Toward and Intention to Participate in the Michigan Medicaid Physician Primary Sponsor Plan (PPSP)," September 6, 1984.

patient-assignment is enforced; but, 60 percent reported that prior authorization was important -- slightly less than the 70 percent reporting patient assignment as important. Finally, 53 percent said that the number of patients per sponsor was important in shaping their opinion about joining PPSP.

Not surprisingly, physicians tended to approve of (either "like" or "strongly like") such provisions as patient assignment and the case management fee in comparison to other features of PPSP. Exhibit 3.4 presents physicians' responses to providing care under the various provisions of PPSP (independent of the provision's importance in deciding to join PPSP). Physicians were evenly split or decidedly neutral about prior authorization of referrals, MDSS monitoring of physician expenditures and use of services, and peer review. They were neutral tending toward negative on 24 hour access, the appeal procedure, the use of cost effectiveness standards and the number of Medicaid patients per sponsor.

The survey of Wayne County physicians also assessed attitudes regarding the likely effects of PPSP. As shown in Exhibit 3.5, at least 50 percent of those surveyed felt that the PPSP would produce decreases in overall service utilization by Medicaid patients, inpatient hospital utilization, emergency room utilization, doctor shopping, drug use, patient abuse of Medicaid, and total costs of Medicaid. On the less positive side, a majority felt that PPSP would have no effect on the quality of the patient-physician relationship or on recipient compliance with physician orders. As many as 49 percent felt that PPSP would have no effect on physician abuse of Medicaid.

3.3. EFFORTS TO RECRUIT PHYSICIANS

In late 1981, the Steering Committee formulated a three-pronged marketing strategy to increase awareness and gain physician involvement: 1) articles about PPSP in local professional medical newsletters and journals, 2) a series of speaking engagements to inform the medical community about PPSP and respond to physicians' specific questions, and 3) letters to individual physicians to

EXHIBIT 3.4

PHYSICIANS' ASSESSMENT OF
MAJOR PPSP PROVISIONS

PPSP Provisions	Percentage Responses			
	Dislike	Neutral	Like	Unfamiliar with Provision
Patient assignment and lock-in	25%	21%	54%	2%
Case management fee	26	28	44	2
Prior authorization of referrals	36	20	42	2
MDSS monitoring of physician expeditures and use of services	30	41	26	2
Twenty-four hour patient coverage	37	39	22	2
Appeals procedure	35	40	14	12
Use of 95th percentile criteria for review	35	41	18	7
Number of Medicaid patients per sponsor	35	48	11	6
Program specifications re HMOs	38	33	5	25
Process of peer review	21	50	19	10

Source: Goldberg, T., "Report on the Survey of Physicians in Wayne County, Michigan on their Attitudes Toward and Intention to Participate in the Michigan Medicaid Physician Primary Sponsor Plan (PPSP)," September 6, 1984.

EXHIBIT 3.5

PHYSICIANS' EXPECTATIONS REGARDING PPSP EFFECTS

Anticipated Effects	Percentage Responses		
	Decrease	No Effect	Increase
Physician reimbursement	40%	44%	16%
Utilization of services by Medicaid patients	50	38	12
Recipient compliance with physician orders	6	62	32
Inpatient hospital utilization	52	45	3
Emergency room utilization	69	26	6
Doctor shopping	91	9	1
Drug utilization	57	43	1
Patient abuse of Medicaid program	76	21	4
Physician abuse of Medicaid program	47	49	4
Total cost of Medicaid	63	25	13
Government involvement in Michigan health care system	12	29	61
Malpractice insurance costs	5	68	28
Medicaid caseload per physician	30	42	28
Quality of physician relationship with Medicaid patients	12	57	31

Source: Goldberg, T., "Report on the Survey of Physicians in Wayne County, Michigan, on their Attitudes Toward and Intention to Participate in the Michigan Medicaid Physician Primary Sponsor Plan (PPSP)," September 6, 1984.

encourage them to join PPSP.(74)

A. The Written Word to All Physicians

From August through October, 1981, three professional medical publications included articles about PPSP. These were the Michigan State Medical Society's (MSMS) Michigan Medicine, the MSMS's Medigram, and the Wayne County Medical Society's (WCMS) Detroit Medical News. In October, Michigan Medicine included a lengthy article which discussed the PPSP and supported its implementation.(75) The following five points were highlighted:

- Reimbursement for the primary sponsor should include the incentive of an administrative fee. This fee should be between $3 and $7.
- The primary sponsor takes "full responsibility for rendering or authorizing all care for the Medicaid recipient."
- Because the primary sponsor makes referrals for other services, the MDSS should provide each sponsor with a list of the referrals made for each recipient.
- Physicians should receive equivalent reimbursement from Medicare and Medicaid.
- The MDSS must take responsibility for educating Medicaid recipients about the threat to their Medicaid benefits. The MSMS and MAOPS must take responsibility for encouraging physician support of this plan.

Overall, the article was positive toward the physician groups' support of PPSP.

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74. PPSP Steering Committee, "Marketing -- Phase I, Agenda Item 6." October 29, 1981; PPSP Steering Committee, "Marketing the Medicaid Proposal," October 29, 1981; PPSP Steering Committee, "Phase I (Marketing Detail), Agenda Item 6-C," October 29, 1981; PPSP Steering Committee, "Implementation Plan, Agenda Item 6," October 29, 1981; PPSP Steering Committee, "Marketing -- Phase I, Agenda Item 6," October 29, 1981.

75. Michigan State Medical Society, "Here is Text of MDs, DOs Proposal for New Medicaid Utilization System," Michigan Medicine, October 1981. At that point, the title was as "Physicians' Proposal for Utilization Management, an Alternative Reimbursement System Under the Michigan Medicaid Program." Upon passage by the Legislature, the Governor renamed it Primary Physician Sponsor Plan.

Two issues of the October MSMS newsletter, Medigram, covered the developing PPSP proposal.(76) The Medigram articles mentioned the status of PPSP but focused on the need for physician support. One article quoted a letter from the director of the MDSS:

> "Let me personally thank you [the physician groups] for your proposal . . . If we are to reduce expenditures in the Medicaid program, a task which must be done, we need the physicians' cooperation. We must move quickly."

Both articles emphasized the heavy involvement of the medical societies in development of the proposal.

On October 30, 1981, the MSMS President sent a letter to all members in Wayne County.(77) The letter provided a detailed summary of the PPSP. In addition, the letter emphasized the medical society's participation in the development of PPSP:

> The proposal for a primary sponsor plan under Medicaid is the result of many hours of diligent work on the part of your colleagues on both the MSMS and MAOP&S Medicaid Liaison Committees. The proposal was approved by The Council of MSMS and the Board of Trustees of MAOP&S in July.... Time is short, and if the plan is to proceed in Wayne County on schedule, we need your participation. I believe the Physicians' Primary Sponsor Plan offers physicians the opportunity to control many of the abuses which plague the Medicaid program and provides incentives to assure quality and cost-effective medical care to Medicaid patients.

The letter concluded by requesting that physicians complete an attached reply card "application" if they were interested in learning more about the plan.

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76. Michigan State Medical Society, "Implementation Underway for MSMS/MAOPS Medicaid Plan," Michigan Medical Medigram, October 16, 1981; Michigan State Medical Society, "MSMS/MAOPS Medicaid Plan Okayed for Implementation," Michigan Medicine Medigram, October 9, 1981.

77. Fryfogle, James, Michigan State Medical Society, "New Medicaid Program to Start in Wayne County. Physicians' Primary Sponsor Plan Accepted by the State," October 30, 1981.

Physician support for PPSP was emphasized by the Wayne County Medical Society. The legislature's acceptance of the physician's proposal was included in the October, 1981, issue of Detroit Medical News. The acceptance letter concluded by endorsing physician participation: "The physician community in this state, through their associations, have confidently endorsed this approach and are willing to assure physician participation."(78)

B. The Spoken Word to Interested Physicians

The Steering Committee set up an agenda of "Speaking Engagements to Inform Physicians and Other Interested Parties" about PPSP. The speaking engagements provided a forum to present the PPSP plan and respond to physicians' questions. This part of the Steering Committee's marketing strategy lasted about four months, from October 14, 1981, to February 8, 1982.(79) The following organizations were included in the circuit of speaking engagements:

- o Wayne County Medical Society Council
- o Michigan State Medical Society Council
- o MAOPS, Mid-Year House of Delegates
- o Wayne County Medical Society Delegate Body
- o Detroit Medical Society
- o Michigan Academy of Family Practice Board of Directors and
- o Wayne County Medical Society General Membership.

In particular, the Steering Committee sought the endorsement of organizations representing specialists. Upon obtaining support for PPSP from specialist's representatives, the Steering Committee publicized this support to all

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78. Wayne County Medical Society, "Michigan Legislature Accepts Physician Proposal for Medicaid Utilization Management," Detroit Medical News, October 19, 1981, and August 10, 1981; Senator Monsma and Representative Hollister, letter to the Director of the Medical Services Administration, October 2, 1981.

79. PPSP Steering Committee, "PPSP Speaking Engagements to Inform Physicians and Other Interested Parties, Agenda Item 6-b," October 29, 1981.

physicians. In addition, the MSMS and MAOPS bought some Detroit television and radio talk show time to explain PPSP and to advertise to physicians generally.(80)

C. Targeted Efforts at Selected Physicians

After implementation of PPSP, the goal of marketing to physicians shifted. Unlike the initial marketing, the effort was not aimed at all Wayne County physicians. Instead, marketing was targeted toward primary care physicians with Medicaid patients who requested that physician for a sponsor. These non-sponsor physicians were particularly important to the MSA because their non-participation in PPSP slowed its implementation and helped delay potential benefits.(81)

The MSA's effort to market PPSP to non-sponsors started in February, 1983, in the form of a short letter. The focus of the letter was on the MSA's desire ". . . not to interfere with existing doctor-patient relationships," a reference to the possibility that MSA would assign the recipient to another physician, who was a sponsor, thus removing that recipient from the physician's caseload. The MSA continuously sent PPSP marketing letters to physicians who did not have sponsor contracts but who were requested by recipients.(82)

Through these targeted letters, at least 129 physician sponsors were added -- about 10 percent of the September, 1984, total. The MSA was able to enroll 30 to 35 percent of the recipients who requested non-sponsor physicians.(83)

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80. PPSP Steering Committee, "Marketing the Medicaid Proposal," October 29, 1981, PPSP Steering Committee, "Marketing -- Phase I, Agenda Item 6," October 29, 1981.

81. Monitoring and Evaluation Committee, "Minutes," December 17, 1982.

82. Monitoring and Evaluation Committee, "Minutes," April 22, 1983; Monitoring and Evaluation Committee, "Minutes," June 3, 1983; Monitoring and Evaluation Committee, "Minutes," August 15, 1983.

83. Department Analyst, Bureau of Program Policy, Medical Services Administration, telephone interviews, Fall, 1984.

However, this approach was limited in terms of the marketing goal of increasing the number of primary care physicians with sponsor contracts and hastening the enrollment of 380,000 recipients. According to the MSA, the targeted physicians usually had small Medicaid caseloads.(84) Therefore adding physicians who signed sponsor contracts because of a recipient's request tended to increase only slightly the overall total of PPSP enrollees. Second, the MSA marketing approach was a reactive policy, which was prompted by recipients requesting non-sponsors. It absorbed resources and effort that were needed to recruit primary care physicians who had not participated in Medicaid before. In effect, it limited the possibility of accomplishing the original objective, increased primary care physician participation in Medicaid.

3.4 SUCCESS OF PHYSICIAN RECRUITMENT EFFORTS

It was hoped that PPSP would appeal both to primary care physicians who had served Medicaid recipients and to those who had not. By late 1984, about 37 percent of the primary care physicians serving Medicaid recipients before PPSP had signed contracts; few (if any) primary care physicians who were not serving Medicaid recipients had been influenced to do so because of PPSP. At the same time, the number of specialists with sponsor contracts was less than five percent of the specialists serving Medicaid recipients under fee-for-service in Wayne County.

After the initial interested group signed contracts, recruitment of sponsor physicians focused on those without sponsor contracts who serve Medicaid recipients interested in enrolling with them under PPSP. Few attempts have been made to reach beyond these desired non-sponsor physicians. Although sponsor caseloads are increasing steadily over time, it is unclear whether the number of currently contracted sponsors is sufficient to serve the number of recipients expected to enroll eventually in PPSP.

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84. Department Analyst, Bureau of Program Policy, and Project Director, Bureau of Medicaid Operations, Medical Services Administration, telephone interviews, Fall, 1984.

A. Type of Physician

Of the estimated 1,162 primary care oriented-sponsors, about half were either in internal medicine or general practice, 329 and 265, respectively. These and other estimates of the types of physicians with sponsor contracts are shown in Exhibit 3.6.(85) As indicated, an estimated maximum of 37 percent of the physicians in primary care-oriented practices who served Medicaid before PPSP had signed sponsor contracts by September, 1984. Indications are that a higher than average percentage of family practice physicians, pediatricians, and to some extent general practitioners, joined PPSP. General surgeons seemed to be participating less. The varied levels of participation among different types of primary care physicians suggests that there might be differences in the pattern of care for recipients. For example, those general surgeons who do participate in PPSP might be less likely than family practice physicians to encourage prevention.

A small portion -- 8.5 percent -- of the physicians with sponsor contracts had specialties not normally associated with primary care case management. These physicians, notably cardiologists and radiologists, were sponsors for recipients with a continuing need for their specialty care. Patients involved in heart disease treatment or cancer patients undergoing radiology treatments exemplify this group. Data on specialists under PPSP contract are shown in Exhibit 3.7.(86) An estimated 4.9 percent of those specialists who served Medicaid before PPSP have signed contracts. About 95 percent of the nonprimary care-oriented physicians lost the ability to initiate care for Medicaid recipients enrolled in PPSP. The care they provide to this group must now be prior authorized by a sponsor physician, which is what the PPSP designers intended.

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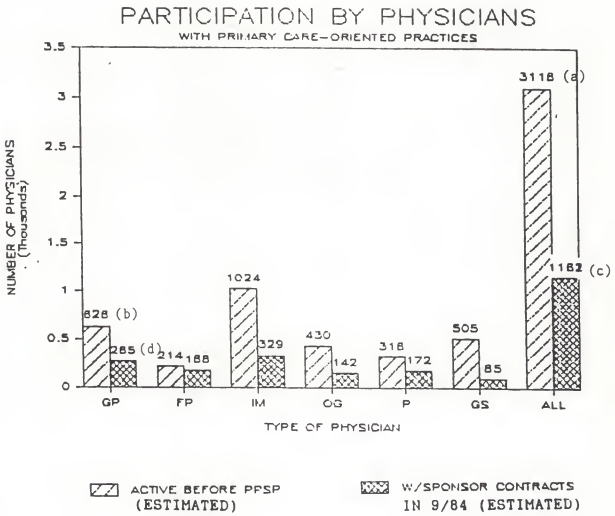
85. Planning and Evaluation Division, Office of Planning, Budget, and Evaluation, Michigan Department of Social Services, Health Care Alternatives Within Title XIX, Fourth Quarter Progress Report, June, 1984, p. 5.

86. Ibid.

EXHIBIT 3.6



GP: General Practice
FP: Family Practice
IM: Internal Medicine
OG: Obstetrics & Gynecology
P: Pediatrics
GS: General Surgery

(a) 5,327 (Number of Medicaid Physicians in Wayne) x 0.585 (the percentage of GP, FP, IM, OG, P, GS physicians in Region 1) = 3116.

(b) GP = 3116 x 0.201 (factor based on percentage active in Medicaid during 4th quarter, 1982)

FP = 3116 x 0.069
IM = 3116 x 0.329
OG = 3116 x 0.138
P = 3116 x 0.102
GS = 3116 x 0.162

(c) 1270 (Number of Wayne County Physicians under PPSP Contract, 9/84) x 0.915 (portion in GP+FP+IM+OG+P+GS)

(d) GP = 1162 x .228 (factor based on percentage of Region I Primary Care-oriented Physicians under PPSP Contract in June, 1983, who were GP Physicians)

FP = 1162 x .145
IM = 1162 x .283
OG = 1162 x .122
P = 1162 x .148
GS = 1162 x .073

EXHIBIT 3.7
SPONSOR CONTRACTS AMONG NON-PRIMARY SPECIALISTS

TYPE OF SPECIALIST	ESTIMATED NUMBER OF MEDICAID SPECIALISTS (A)	ESTIMATED MAXIMUM NUMBER WITH SPONSOR CONTRACTS (B)	PERCENT OF SPECIALISTS WITH PPSP CONTRACTS
CARDIOLOGY	217	28	12.9
RADIOLOGY	314	20	6.4
OTHER SPECIALTY (C)	1680	60	3.6
ALL	2211 (D)	108 (E)	4.9

(A) CARDIOLOGY = 2211 X 0.098 (FACTOR BASED ON PERCENTAGE ACTIVE IN MEDICAID DURING 4TH QUARTER, 1982)

RADIOLOGY = 2211 X 0.142
OTHER = 2211 X 0.760

(B) CARDIOLOGY = 108 X 0.258 (FACTOR BASED ON PERCENTAGE OF REGION 1 SPECIALISTS UNDER PPSP CONTRACT IN JUNE, 1983, WHO WERE CARDIOLOGISTS)

RADIOLOGY = 108 X 0.183
OTHER = 108 X 0.559

(C) INCLUDES: ALLERGY, ANESTHESIOLOGY, DERMATOLOGY, NEUROLOGY, NEUROLOGICAL SURGERY, OPHTHAMOLOGY, ORTHOPEDIC SURGERY, OTOLARYNGOLOGY, PATHOLOGY, PHYSICAL MEDICINE AND REHABILITATION, PLASTIC SURGERY, PROCTOLOGY, PSYCHIATRY, THORACIC SURGERY, AND UROLOGY.

(D) 5,327 (NUMBER OF MEDICAID PHYSICIANS IN WAYNE) X 0.415 (THE PERCENTAGE OF SPECIALIST PHYSICIANS IN REGION 1) = 2211.

(E) 1270 (NUMBER OF WAYNE COUNTY PHYSICIANS UNDER PPSP CONTRACT, 9/84) X 0.085 (PORTION IN SPECIALTIES)

B. Size of Sponsor Caseloads

Although sponsors may have as many as 2,000 PPSP enrollees, as of September, 1984, only 19 physicians had reached caseloads of between 400 and 900 recipients. (See Exhibit 3.8.) A closer look at the data shows that in April, 1984, there was an average of 29 PPSP enrollees per sponsor; by June, 1984, the average caseload had risen to 44. While the size of sponsors' PPSP caseloads was growing, most sponsor physicians were serving PPSP and non-PPSP Medicaid recipients simultaneously, with the latter often the larger group.

C. Practice Settings

An MSA study of sponsors associated with large groups was to be completed in late 1984, after completion of this review. Therefore, data on the distribution of sponsors by practice setting were as yet unavailable. Similarly, there was little readily available information on the affiliations among sponsor physicians. The available information indicated, however, that the majority of sponsors were in solo or small group practice and had minimal formal affiliations with other care providers. Some sponsors practiced in large groups and clinics and had multiple affiliations. These distinctions are important to the PPSP evaluation because of differences that may exist, such as practice pattern, office location and organization, and relative value of case management fees. For example, in comparison to solo practitioners, how do clinics comply with the provision to "render 50 percent care?"

D. Geographic Location

As of late 1984, the availability of sponsor physicians varied considerably across Wayne County locations, as shown in Exhibit 3.9. With 40 recipients per sponsor, LaFayette/Rosa Park in central Detroit enjoyed the lowest (best) ratio. At the opposite end of the spectrum, one sponsor was available for every 1,379 recipients in Fullerton/Jefferies, a neighborhood located north of central Detroit. The average across all locations was 242 recipients per sponsor. Data were not available for two districts within Wayne County -- McNichols and

Exhibit 3.8

PPSP SPONSOR CASELOAD SIZES[a]

Month/ Year	Total No. Sponsors	Caseload Size[b]					
		1-20	21-40	41-100	101-200	201-400	401+
July '83	759	581	94	69	14	1	0
Aug. '83	809	612	92	84	19	2	0
Sept.'83	863	633	97	105	26	2	0
Dec. '83	923	640	132	109	35	7	0
Mar. '84	995	554	185	160	65	30	1
June '84	1087	624	175	168	67	38	15
Sept.'84	1109	626	180	163	76	45	19

(a) Groupings for the number of recipients in caseloads were developed from official documents found in the sources below.

(b) Sponsors with a caseload of zero are not included.

Sources: Michigan Department of Social Services, Planning and Evaluation Division, Health Care Alternatives Within Title XIX, Quarterly Report for July-September, 1983, November, 1983.

PPSP Steering Committee, "Sponsor Caseload and Related Statistics," June 18, 1984.

PPSP Steering Committee, "Sponsor Caseload and Related Statistics," August 1, 1984.

Exhibit 3.9

SPONSOR/HMO AVAILABILITY BY DISTRICT

District	Recipients	Sponsor Physicians	Recipients Per Sponsor	Recipients Per HMO site
1.Lafayette/ Rosa Parks	6,608	167	40	2,203
2.Rosa Parks	8,729	105	83	4,365
3.Medbury/ Concord	10,070	105	96	10,070
4.Redford	13,428	126	107	2,686
5.Tireman/ Central	14,016	128	110	28,032
6.Grand River/ Warren	11,261	77	146	5,631
7.Highland Park	11,671	66	177	2,334
8.Taylor	13,110	67	196	4,370
9.Kercheval/ Townsend	9,808	50	196	4,904
10.Lincoln Park	14,624	74	198	4,875
11.Schaefer/ McNichols	12,774	58	220	4,258
12.Algonquin/ Jefferson	12,091	52	233	4,030
13.Inkster	9,984	42	238	4,992
14.Romulus	13,183	54	244	26,366
15.Joy/ Greenfield	15,797	61	259	3,159
16.Greydale/ Grand River	14,010	48	292	3,503
17.Fort/ Military	14,474	48	302	---
18.Boulevard/ Magnolia	11,851	38	312	11,851
19.Forest/ Ellery	10,381	33	315	5,191
20.Madeline/ Gratiot	18,609	51	365	18,609
21.Oakman/ Grand River	15,247	28	545	30,494
22.Schoolcraft/ Stansbury	15,428	25	617	---
23.Harper/ Gratiot	12,244	18	680	---
24.Conner/ Warren	12,915	16	807	---
25.Fullerton/ Jeffries	16,544	12	1,379	16,544
26.McNichols	15,808	0	---	---
27.Holbrook	16,463	0	---	---
Total	351,178	1,452	242	6,432

Holbrook.(87) There are several possible explanations for the highly variable distribution of physician-sponsors, including variation in the number of physicians available generally, variation in the number participating in Medicaid, and variation in the number of physicians reluctant to sign sponsor contracts.

E. Conclusion

Overall, it is clear that the PPSP has not yet attained its objective of increasing the number of primary care-oriented physicians serving Medicaid. Even further, PPSP has attracted only one-third of primary care-oriented physicians who served Medicaid before. However, PPSP has effectively limited the number of non-primary care specialists with sponsor contracts; and with 1,270 physicians under contract as of September, 1984 (See Exhibit 3.10), it already had the largest number of participating private physicians of any Medicaid PCCM in the nation.

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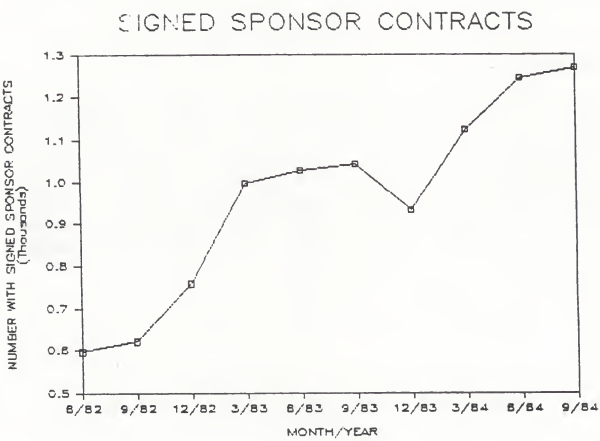
87. Paul M. Allen, Director, Medical Services Administration, memo to the Honorable Juanita Watkins, Re: Health Care Resources for the Poor, April 12, 1984.

EXHIBIT 3.10



DATE	NUMBER
6/82	597
9/82	622
12/82	759
3/83	996
6/83	1028
9/83	1044
12/83	932
3/84	1124
6/84	1245
9/84	1270

SOURCE: MDSS, OFFICE OF PLANNING AND EVALUATION, HEALTH CARE ALTERNATIVES WITHIN TITLE XIX, QUARTERLY REPORT, NOVEMBER, 1984.

CHAPTER 4

ENROLLING RECIPIENTS

4.1 EFFORTS TO ENROLL RECIPIENTS

A. Phase One -- Stringent Mandatory Enrollment (July, 1982 -- March, 1984)

Brochures to Selected Recipients. During the first 21 months of PPSP, recipient enrollment involved mailing brochures to selected recipients and requiring them to respond by telephone to the Sponsor Specialists and choose an HMO or PPSP sponsor. Brochures were mailed to the heads of households. The MSA expected to enroll the recipient's entire family when the head of household telephoned the Sponsor Specialists. The MSA estimated that there were three Medicaid recipients per household; therefore, each brochure should have triggered about three enrollments. In addition, physicians who were sponsors posted notices about PPSP in their offices. These notices were not monitored by the MSA or MLHS. Therefore, the breadth of information in these notices and their impact cannot be assessed.

Recipients were expected to make telephone contact within 15 days to select PPSP or one of the other delivery plans. While many recipients enrolled as planned through telephone contact with the Sponsor Specialists, many others either failed to make contact or selected a non-sponsor physician. For example, in January, 1984, the MLHS reported that 30-40 percent of the recipients chose non-PPSP sponsor physicians.(88) A modest incentive for recipients to join PPSP was added in late 1983 when MDSS announced that PPSP enrollees would be exempt from co-payments on prescription drugs.

The first large-scale mailing of brochures was to a group of recipients who almost qualified for Michigan's Recipient Monitoring Project, a program to control excess service utilization. The MSA decided to send brochures to these recipients in lieu of enrolling them in Recipient Monitoring. After about one month, these brochure mailings were ended because most high service users had

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88. Monitoring and Evaluation Committee, "Minutes," January 16, 1984.

been contacted and because sponsors expressed dissatisfaction with the notion of their PPSP caseload composed of higher users.(89)

A series of five initiatives were implemented to enroll recipients who either did not respond to the brochure or encountered difficulties when trying to enroll. Basically, the initiatives had two common thrusts that eventually proved unacceptable: assign individuals to a physician with a sponsor contract or require the non-enrolled to obtain prior authorization for all non-emergency care through the Sponsor Specialists.

In the remainder of this section, the duration, target group, key requirements, and number of recipients involved in each initiative are reported. As well, we describe associated problems and effects on the Sponsor Specialists' workload. This information on the five initiatives and on the original enrollment brochure effort is summarized in Exhibit 4.1, "An Overview of Phase One Enrollment Initiatives."

Second Notices. Beginning in October, 1982, and continuing through March, 1983, a second notice of the requirement to enroll in one of the alternative plans was sent to recipients who had received the brochure but had not selected a sponsor. The objective of second notices was to increase PPSP enrollment to 60-70 percent of those receiving brochures.(90)

A total of 3960 second notices were sent by April, 1983. Between October, 1982, and February, 1983, about 46 percent of these resulted in a call to the Sponsor Specialists to enroll in one of the plans.(91) Nonetheless, in April, 1983, the MSA decided to discontinue the second notice mailings. It was felt that the response rate was not great enough to justify the amount of time which the Sponsor Specialists had devoted to these mailings.(92)

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89. Project Director, Bureau of Program Policy, Medical Services Administration, site visit, June, 1984.

90. Michigan League for Human Services, "Physician Primary Sponsor Plan Monitoring Project: Monthly Report," April 7, 1983.

91. Ibid.

EXHIBIT 4.1

AN OVERVIEW OF PHASE ONE ENROLLMENT INITIATIVES

Initiative	Duration			Number Messages Sent	Target Group	Recipient Requirement	Sponsor Specialist Workload	Problems
	Start	End	Months					
A. Enrollment Brochures Medicaid Sponsor Plan (MSP)	6/82	3/84	22	53,000+ (affecting 150,000 recipients)	1. 56 recipients who would be likely to select a sponsor. 2. one mailing (400 brochures) to high health care system users. 3. Health care system users, beginning with low ID numbers.	Enroll by calling within 15 days or else assignment will be made with option to change.	Respond to brochure enrollment calls.	1. Recipients select non-sponsor physician. 2. Recipients do not respond to brochure.
B. Second notices	10/82	3/83	6	3,960	Recipients not responding to a MSP brochure.	Enroll in 5 days or be assigned to the sponsor listed in the notice.	A & process second notices.	Sponsor Specialists manually had to process notices (clerical task).
C. Pend status	5/82	3/83	10	4,479+	Recipients who select non-sponsors; waiting for physician to become a sponsor.	None. Obtain medical care through fee for service.	Market PPSP to recipient-selected nonsponsors.	Marketing to non-sponsors unsuccessful and time consuming.
D. MSA Designation	6/83	4/84	10	4,644 (peak)	1. Recipients who select non-sponsors (formerly pended). 2. Recipients who do not respond to MSP brochure.	Obtain prior authorization from Sponsor Specialists at which time recipient is enrolled with physician that receives authorization. 30 60-day limit for MSA designation, then recipient returns to FFS.	A & B & authorizations for care & enrolling MSA designeted recipients.	Sponsor Specialists had to respond to recipient and provider questions about designations & carry out the related responsibilities (clerical task).
E. Blind Assignment	5/82	5/83	12	4,227	Recipients not responding to MSP brochure or second notice.	Follow PPSP procedures with sponsor listed on Medicaid card.	A & B & D & determine provider assignment by zip code.	Poor assignments yielded questions, changing providers, and disenrolling.
F. Computer-match	4/83	4/84	10	14,585	Recipients not responding to MSP brochure or second notice.	Follow PPSP procedures with sponsor listed on Medicaid card.	A & D & respond to computer-match questions. MSA assigns recipient to sponsor physician seen in last six months. If no sponsor sees, recipient remains in FFS.	

Responding Recipients: "Pend" status and MSA Designation. During the period July, 1982, through March, 1984, many recipients made an attempt to enroll with PPSP, but their desired physician was not a sponsor. In these cases, at least 5,000 in total, the recipients were given a "pend" status. They continued to receive care under the fee-for-service system while they waited for their selected physician to sign a sponsor contract. Exhibit 4.2 shows the number of recipients put on "pend" status between May, 1982, and March, 1983. By February, 1983 roughly 2,800 recipients had a pend status. One month later, approximately 4,479 recipients had pend status.

The MSA terminated the use of pend status as of March, 1983. Shortly before, in February, the Sponsor Specialists actively began trying to gain sponsor contracts with physicians who were desired by recipients on pend.(93) The remaining recipients who had not selected another physician or whose chosen physician had not become a sponsor were given MSA designations.

This designation meant that the recipients needed prior authorization of non-emergency care. These PPSP enrollees first called the Sponsor Specialists who, in turn, telephoned an appropriate physician. Sponsor Specialists would facilitate linking enrollees to sponsors while processing the request for authorization. It was expected that recipients with MSA designation, or MSA "assignees", would enroll with physicians seeking authorization to serve them. If the physician was a sponsor, the effort would concentrate on getting the recipient to enroll with that physician. If the physician was not a sponsor, the request for authorization would provide an opportunity for recruiting. In short, it was expected that prior authorization simultaneously would put immediate control on utilization of services by recipients not easily enrolled

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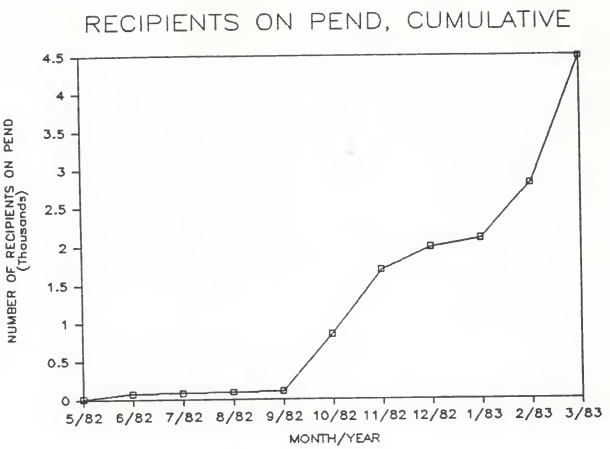
92. Michigan League for Human Services, "Physician Primary Sponsor Plan Monitoring Project: Interim Report," April 19, 1983.

93. Michigan League for Human Services, "Physicial Primary Sponsor Plan Monitoring Project," Monitoring and Evaluation Committee Reports, December, 1982, through January, 1984;

EXHIBIT 4.2



*DATE	RECIPIENTS ON PEND
5/82	12
6/82	75
10/82	852
11/82	1695
12/82	1989
1/83	2100
2/83	2817
3/83	4479

* DATES REFER TO BROCHURE MAILING FOR WHICH RECIPIENTS WERE PUT ON PEND STATUS.

SOURCE: MICHIGAN LEAGUE FOR HUMAN SERVICES, MONITORING AND AND EVALUATION COMMITTEE, "MINUTES", DECEMBER, 1982, TO APRIL, 1983.

and it would hasten their eventual enrollment.(94)

Because many recipients had MSA designations, over 4,000 by late July, the Sponsor Specialists became increasingly busy enrolling recipients with MSA designations and/or responding to providers' requests for authorization of care. The Sponsor Specialists reported that MSA designations were becoming too numerous for efficient servicing."(95) Three specific problems emerged. First, the Sponsor Specialists could not handle the number of calls generated. There were not enough professional and clerical staff answering telephones to ensure the administrative feasibility of the MSA designations. Both the volume of calls from recipients and providers, and the insufficient phone lines to handle the volume led to difficulties.

A related second problem was that providers became leery of recipients with an MSA designation because they knew about the busy telephone lines at the Sponsor Specialist office. In July, 1983, the Monitoring and Evaluation Committee reported:

> Providers are to call for authorization for care on the same phone lines on which enrollment calls are received. Many report telephoning for three days before making contact with the MSA office. Providers are now starting to turn MSA assignees away without even attempting to contact the [Sponsor Specialist] office.96)

Reportedly, recipients were being denied care because providers were unable to get through to the Sponsor Specialists for authorization. The Sponsor Specialists were receiving "approximately five calls per day from recipients who had been denied care due to problems with MSA assignments."(97)

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94. Department Analyst, Bureau of Program Policy, site visit interviews, June, 1984.

95. Michigan League for Human Services, "Physician Primary Sponsor Plan Monitoring Project: Monthly Report," July 18, 1983.

96. Monitoring and Evaluation Committee, "Minutes," July 13, 1983.

97. Michigan League for Human Services, "Physician Primary Sponsor Plan Monitoring Project: Final Report," September 20, 1983.

A third problem was that the time limit on the MSA designation forced some recipients to select sponsors whom they did not necessarily desire. The MSA designation was not to last longer than 30 to 60 days. Recipients were then required to select a sponsor, perhaps in lieu of their originally requested, non-sponsor, physician. There were to be no exceptions for those recipients whose special circumstances might dictate that they remain with their provider, whether enrolled as a sponsor or not.(98)

Finally, in January, 1984, the MSA decided to disenroll all PPSP enrollees with an MSA designation.(99) This disenrollment became effective for most recipients as of February 1, 1984, when MSA designees received a "clean" Medicaid card without a Sponsor stamp. One month later, a short notice explaining the disenrollment went out to all PPSP enrollees with their March Medicaid cards. The notice went to all PPSP enrollees because MSA was unable to isolate only those recipients who were affected by the MSA designation. By April, 1984, no recipients received Medicaid cards with MSA designations. The disenrolled recipients used the fee-for-service system and were sent Medicaid Sponsor Plan brochures at a future date.(100)

In retrospect, the MSA does not consider the MSA designations to have been a good alternative for recipients who were on pend status. The MSA designations included the requirement that recipients obtain prior authorization for non-emergency medical care. This requirement proved to be unproductive and time-consuming.

Non-responding recipients: Blind Assignments and Computer Matching. Some recipients did not respond to the Medicaid Sponsor Plan brochure nor did they respond to the second notice. Therefore, in June, 1982, the MSA began to assign

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98. Ibid.

99. Michigan League for Human Services, "Physician Primary Sponsor Plan Monitoring Project: Annual Report," October 1, 1984.

100. Michigan Department of Social Services, "Notice to Recipients in Wayne County," March, 1984.

them "blindly" to sponsors or HMOs with the same zip code; 80 percent were assigned to PPSP sponsors, 20 percent were randomly assigned to HMOs. The MSA flowchart of procedures for sponsor and HMO assignment and the MSA letter to blindly assigned enrollees are presented in Exhibit 4.3 and Attachment 4.1, respectively.

Approximately 4,000 recipients had received an assignment by mid-April, 1983, as shown in Exhibit 4.4. However, the Sponsor Specialists discovered several problems with these assignments:

> Most of these recipients were unaware that an assignment had been made, and experienced numerous problems when attempting to seek medical care from a physician other than the one to whom they had been assigned. Recipients were given no information as to the location of their assigned physician's office, making it difficult to know where to begin to get care. Several recipients were assigned to inappropriate providers (e.g., a middle-aged woman being assigned to a pediatrician).(101)

By May, 1983, nearly 800 assigned recipients had telephoned the Sponsor Specialists to change providers. In addition, recipients with blind assignments were likely to telephone the Sponsor Specialists to clarify misunderstandings about them. This increased the Specialists' telephone workload appreciably.(102)

The Monitoring and Evaluation Committee suggested that in lieu of "blind" assignments, "computer-match" assignments be made for recipients who did not respond to the Medicaid Sponsor Plan brochure. In conducting a computer-match assignment, a recipient would be assigned to a physician who both was a sponsor and had given medical care to the recipient most recently.(103) As a backup, if the computer-match was unsuccessful, recipients were given an "MSA" designation.

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101. Michigan League for Human Services, "Physician Primary Sponsor Plan Monitoring Project: Interim Report," April 19, 1983.

102. Michigan League for Human Services, "Physician Primary Sponsor Plan Monitoring Project: Final Report," September 20, 1983.

103. Michigan League for Human Services, "Physician Primary Sponsor Plan Monitoring Project: Interim Report," April 19, 1983.

Exhibit 4.3

MSA PROCEDURES FOR ASSIGNMENT TO HMO OR SPONSOR

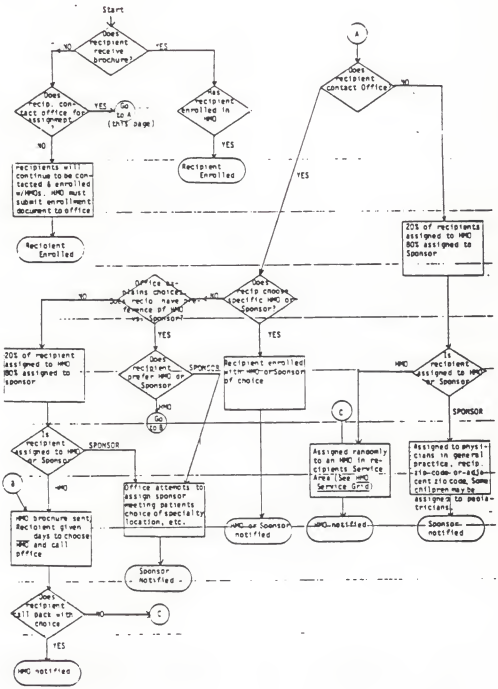
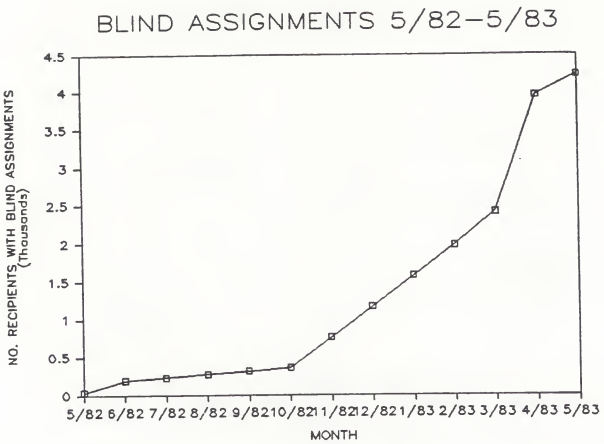

Start
Does Recipient receive brochure?
NO
YES
Does Recip. contact office for assignment?
YES
Go to A (NEXT page)
NO
Has Recipient enrolled in HMO
YES
Recipient Enrolled
recipients will continue to be contacted & enrolled w/HMOs. HMO must submit enrollment document to office
Recipient Enrolled
A
Does Recipient contact Office?
NO
YES
20% of recipients assigned to HMO &20% assigned to Sponsor
Office assigns choice recip. have preference of HMO vs. Sponsor?
NO
YES
Does recip choose specific HMO or Sponsor?
NO
YES
20% of recipient assigned to HMO &20% assigned to sponsor
Does recipient prefer HMO or Sponsor?
SPONSOR
HMO
Go to B
Recipient enrolled with HMO or Sponsor of choice
Is recipient assigned to HMO or Sponsor
HMO
SPONSOR
C
Assigned randomly to an HMO in recipients Service Area (See HMO Service Grid)
Assigned to physicians in general practice, recip.-in-comm.-or-adjacent zip codes. Some children may be assigned to pediatricians
B
HMO
SPONSOR
HMO brochure sent, Recipient given 5 days to choose HMO and call office
Office attempts to assign sponsor meeting patients choice of specialty location, etc.
HMO or Sponsor notified
HMO notified
Sponsor notified
Sponsor Notified
Does Recipient call back with choice
NO
C
YES
HMO notified

EXHIBIT 4.4



DATE	BLIND ASSIGNMENTS
5/28/82	39
6/29/82	152
10/11/82	166
1/11/83	1218
3/01/83	828
4/04/83	1545
5/06/83	279
TOTAL	4227

SOURCE: PPSP STEERING COMMITTEE, HANDOUTS, NOVEMBER, 1982 AND MARCH, 1983, AND MICHIGAN LEAGUE FOR HUMAN SERVICES, MONITORING AND EVALUATION COMMITTEE, "REPORTS", MARCH TO MAY, 1983.

The goal for implementation of the computer-match policy was February, 1983. However, the blind assignment policy was not suspended until April, 1983, and computer-match and MSA designations did not begin until June.

The recipients' records of use of Medicaid services (FM-130 Report) were analyzed to identify any sponsor physician(s) serving the recipient in the previous six months.(104) If so, the recipient was assigned (unilaterally enrolled) to the sponsor seen most recently. Recipients had the option to disenroll.

The MSA steadily matched recipients to sponsors by computer until February, 1984, when the procedure was held in abeyance for several months. Although recipients lodged few complaints concerning computer matches, the procedure was terminated in April, 1984, in favor of a less stringent approach to recipient enrollment.

Though not conclusive, the available evidence indicates that the mandatory enrollment approach employed in the first 22 months collapsed under the pressure of its own weight. Specifically, it appears that the requirements for resources grew continuously while the level of resource commitment was steady or decreasing. Within a short time, the capacity of available resources was exhausted while the requirements continued to grow. Eventually, the only solution was to disenroll the difficult to manage enrollees -- i.e., those not voluntarily (or acceptably) enrolled with a sponsor -- and begin anew.

B. Phase Two Enrollment (Beginning March, 1984)

The recipient enrollment process was tightly controlled until late 1983. That is, recipients who did not telephone the Sponsor Specialists to enroll were then enrolled with a sponsor or their use of Medicaid was controlled through prior authorization by MSA. During that phase, several problems were encountered, so a better method was sought, one that would be less mandatory for recipients and less reliant on the Sponsor Specialists.

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104. Report Number FM-130, Automated Match, Physician Sponsor Program.

The second phase, as depicted in Exhibit 4.5, is characterized by three modes of enrollment: 1) recipient-initiated, 2) (sponsor) physician-assisted, and 3) caseworker-assisted. Each begins at a different point, and none depends heavily on the Sponsor Specialists or on telephone contact. In response to a written announcement sent to all Wayne County recipients in March, 1984 (or other communications), a recipient can make an enrollment application or a request for more information by mail to MSA in Lansing. In a reversal of earlier policy, sponsor-physicians can provide recipients with an enrollment application; and, while not allowed to coerce recipients, sponsors may submit signed enrollment applications to MSA in Lansing. The third mode involves MDSS District Offices in Wayne County. As recipients become eligible for Medicaid or are notified to schedule their yearly eligibility redeterminations, they are provided with information about PPSP and other plans. Recipients are told, "If a plan is not chosen you may be assigned to a PPSP sponsor or an HMO in the future."(105)

Recipient-Initiated Enrollment. In the March, 1984, mailing of Medicaid cards, all Medicaid eligible recipients received notification that the pharmacy co-payments were eliminated for PPSP enrollees. Also included was a flyer with a pre-addressed tear-out form. The form enables recipients to choose among the HMO, CAP, and PPSP programs or to signify that they want more information concerning any or all of the plans.(106) This enrollment method responds to the many recipient complaints about earlier enrollment methods, specifically MSA designations and blind assignments.

By April 2, MSA reported approximately 2,300 responses requesting information on the options. This represents about one percent of those receiving the March flyer who were not enrolled in a plan already.(107) According to the June

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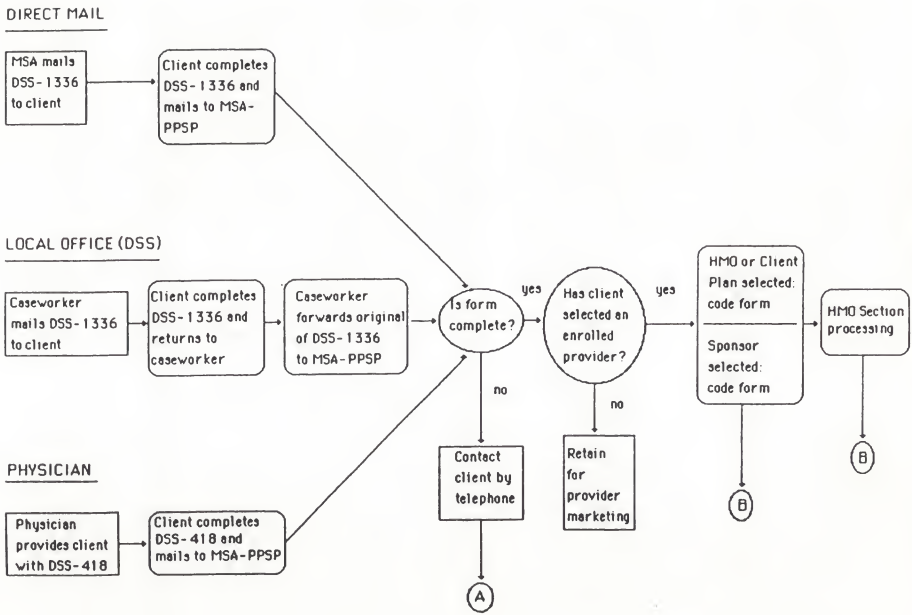
105. Michigan Department of Social Services letter to recipients at intake or redetermination.

106. Medical Services Administration, Michigan Department of Social Services Administration, "Notice to Medicaid Recipients," March, 1984.

107. In March, 1984, there were 119,344 recipients enrolled in one of the three health care delivery plans; therefore, of the 380,018 PPSP eligible recipients,

EXHIBIT 4.5: MSA PROCEDURES FLOWCHART FOR PPSP RECIPIENT ENROLLMENT



15, 1984, MLHS Interim Report, most clients request information on all three options. The MSA in Lansing mails the requested information, an enrollment form, a post-paid return envelope, and instructions to complete and mail the form.(108) MSA made no substitutions for the second notice or computer-match, or pend policies; therefore, unlike the process during phase one, if a recipient does not respond to the flyer, then no assignment is made to a sponsor or MSA.

Physician-Assisted Enrollment. Another point of enrollment is a recipient's physician, if the physician is a sponsor. When PPSP was started, welfare rights and advocacy groups were opposed to any form of physician marketing for fear of coercion. However, due to the slower-than-expected rate of PPSP enrollment, physician marketing is now encouraged. This method responds to sponsor complaints about their small PPSP caseloads. Sponsor physicians can now increase their PPSP caseloads by encouraging enrollment of Medicaid recipients they serve already.

The enrollment pamphlet used by physicians, Medicaid Sponsor Plan, You Can Enroll As My Patient (see Attachment 2.2), is made available in the sponsor's office.(109) Although eligible recipients cannot be coerced by a sponsor or the sponsor's staff, the physician's office can be used as an opportunity to make recipients aware that their physician is a sponsor and that PPSP may offer some advantages. That is, in the context of serving patients, the sponsor can attempt to explain PPSP and provide them with an enrollment form. For example, a sponsor's office staff might learn from the medical file that a recipient is not enrolled in PPSP. While serving the individual, the sponsor can inform the recipient about PPSP. If the recipient completes the PPSP enrollment form while in the sponsor's office, the sponsor may mail the form to MSA. Usually, the MSA

260,674 were not enrolled in any plan. Two thousand, three hundred recipients responded to the MDSS Medicaid flyer: 2300 represents 0.9 percent of the 260,674 eligible, but not enrolled recipients.

108. Michigan League for Human Services, "Physician Primary Sponsor Plan Monitoring Project: Interim Report," June 15, 1984.

109. Medical Services Administration, "Medicaid Sponsor Plan, You Can Enroll As My Patient," March, 1984, through the present.

receives batches of ten to twelve enrollment forms; however, some physicians have sent batches with as many as 100 forms.(110)

The Sponsor Specialists maintain a file of complaints.(111) During two months, between April 23, 1984, and June 21, 1984, the Sponsor Specialists received 14 complaints about sponsors enrolling recipients. This represents less than one percent of the recipient population enrolled with sponsor assistance during the same period. About one-third of the complaints were from recipients who denied signing a PPSP enrollment form. Another one-third of the complaints were from recipients who felt that if they did not sign up with this sponsor, they would not receive services. Some of the recipients thought they were enrolling for services for that day only, not realizing they would receive care from the same physician on a continuing basis. The following chart summarizes the complaints:

CLIENT COMPLAINTS REGARDING
PHYSICIAN ENROLLMENT METHODS

coerced	4
never saw physican before	2
denies signing anything	5
ramifications of signing not explained	3
	14

The Sponsor Specialists refer all complaints to the MSA. The MSA resolves complaints by disenrolling the recipient or changing the sponsor.

Caseworker-Assisted Enrollment. A third mode of enrollment is facilitated by caseworkers stationed at the local MDSS District Offices serving Wayne County

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110. Monitoring and Evaluation Committee, "Minutes," May 31, 1984.

111. Supervisor, Medicaid Sponsor Office, memo to the Division Director, Bureau of Health Services Review, Medical Services Administration, RE: Report Complaints June 22, 1984, Physician Enrollment Methods; Project Director, Bureau of Medicaid Operations, Medical Services Administration, telephone interview, February, 1985.

recipients, specifically at intake or annual eligibility redetermination. For those recipients who lose and then regain their eligibility, an intake interview may serve as a (second) exposure to PPSP. In addition, once a year recipients receive notice from the District Office that they must meet with their caseworkers for eligibility redetermination. Included with the notice is a letter with information about the health care delivery options as well as an enrollment form. Recipients are instructed to bring the enrollment form to their caseworkers.(112) Recipients have several weeks to make an appointment at their convenience. When meeting with caseworkers, for the first time or at redetermination, recipients are informed again about the options for health-care delivery under Medicaid. If a recipient decides to enroll in PPSP, the caseworker fills out the enrollment form, DSS-1336, which includes the name of the proposed sponsor physician for each family member. This form may also be used for enrolling a recipient in an HMO or CAP. The role of the caseworker is to ensure that the form is complete, and to refer any questions to the Sponsor Specialists. The first PPSP information flyer was sent to recipients going through redetermination in January, 1984.(113)

The local caseworkers receive training from MSA about the PPSP option for recipients and how to complete the enrollment application. The PPSP Project Director, based in MSA Lansing, has the responsibility for training the District Office caseworkers. During this three-hour seminar, caseworkers are provided with the following: the notification which a recipient receives about HMOs, PPSP, and CAP; short descriptions of each option; directions for completion of the PPSP enrollment application; a copy of the application (DSS-1336); and a discussion of the major concerns of clients about the PPSP program. The

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112. Michigan Department of Social Services, "Medicaid Enrollment Request for Wayne County," and cover letter.

113. Monitoring and Evaluation Committee, "Minutes," December 16, 1983; Caseworkers, Forest Ellery Michigan Department of Social Services District Office, site visit, June, 1984. In deciding to enroll recipients with the assistance of caseworkers, concern was raised about caseworkers' recipient enrollment ability. "It is unlikely that workers will have time to adequately inform recipients of the choices between PPSP, HMOs, and CAPs." Michigan League for Human Services, "Physician Primary Sponsor Plan Monitoring Project: Interim Report," December 19, 1983.

caseworkers also receive copies of all notices sent to recipients. In this way, "they are aware of the content and timing of the information sent to recipients."(114)

In discussions with caseworkers at one participating District Office, some of the difficulties with PPSP enrollment emerged. First, although the caseworkers could easily fill out the PPSP forms, it was not a priority to them. They had seven other more significant forms related to eligibility and benefits which had to be completed first. Second, if a recipient wanted to enroll in PPSP, the caseworkers did not have time to verify that the recipient was not already enrolled in one of the other plans. Nor did the caseworkers have time to verify that the recipient was in fact choosing a physician with a sponsor contract. Furthermore, many caseworkers considered PPSP to be a pilot program, so some caseworkers were not confident yet that they should recommend it to their clients. A caseworker noted that her clients were wary of any change that could affect their health care. In addition, some caseworkers were thought to be opposed to PPSP or HMOs and either discouraged recipients from joining or did not mention the options.(115)

4.2 SUCCESS OF RECIPIENT ENROLLMENT EFFORTS

The first section of this chapter described the various modes of recipient recruitment used during the first 26 months of PPSP implementation. By September, 1984, 53,940 recipients were enrolled -- an estimated 18 percent of the original number targeted for PPSP enrollment. Data on recipient enrollment are shown in Exhibit 4.6, which includes the distinction between target and actual

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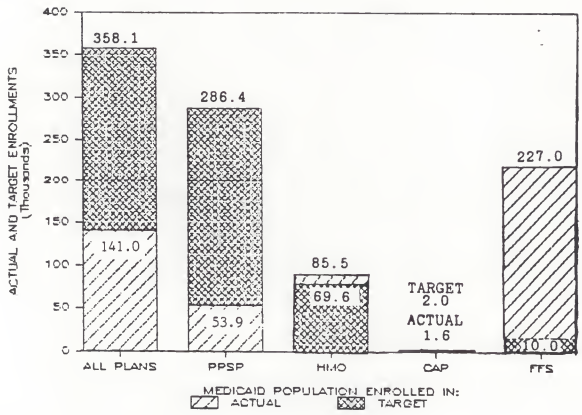
114. Monitoring and Evaluation Committee, "Minutes," January 16, 1984.

115. Caseworkers, Forest Ellery Michigan Department of Social Services District Office, site visit, June, 1984; Monitoring and Evaluation Committee, "Minutes," January 30, 1984.

EXHIBIT 4.6

ENROLLMENT SUMMARY, SEPTEMBER, 1984



	ACTUAL		TARGETED	
	NUMBER	PERCENT	NUMBER	PERCENT
MEDICAID POPULATION*	368,041	100.0	368,041	100.0
ENROLLED IN:				
ALL PLANS	141,049	38.3	358,104	97.3
PPSP	53,940	14.7	286,448	77.9
HMO	85,495	23.2	69,656	18.9
CAP	1,614	0.4	2,000	0.5
FFS	226,992	61.7	9,981	2.7

* TOTAL ELIGIBLE MEDICAID POPULATION, EXCLUDING LONG TERM CARE RECIPIENTS, SEPTEMBER, 1984.

(estimated) levels of participation.(116) There were specific targets for each plan and it was expected that all but a small fee-for-service (comparison) group needed for evaluation would be enrolled as early as July, 1983. In sum, as of September, 1984, the PPSP enrollment was at about one-fifth of the original target, HMO enrollment was somewhat higher than projected, and an unexpectedly large group of recipients remained under fee-for-service.

The monthly record of PPSP recipient enrollment and case management fee expenditures in Exhibit 4.7 shows the slow start that occurred before recipient recruitment began to intensify in the last months of 1982 and the first months of 1983. This was followed by several months of much faster growth that was still far below the pace needed to reach PPSP enrollment targets by the end of 1983 or 1984. Beginning in late 1983 and early 1984 there was a further increase in the pace of enrollments, yet it was still considerably less than the rate needed to achieve enrollment targets by December, 1985.

A. Success of Mailed Brochures and Mandatory Enrollment

The cumulative results of mailing brochures between July, 1982, and March, 1984, are summarized in Exhibit 4.8. Of the recipients for whom the brochures should have triggered a response, less than one-quarter enrolled in PPSP by March, 1984. Furthermore, as the data indicate, this percentage of targeted enrollment was achieved slowly.

In describing this choice-forcing phase of recipient enrollment, we noted three problems that made stringent mandatory enrollment difficult to manage.

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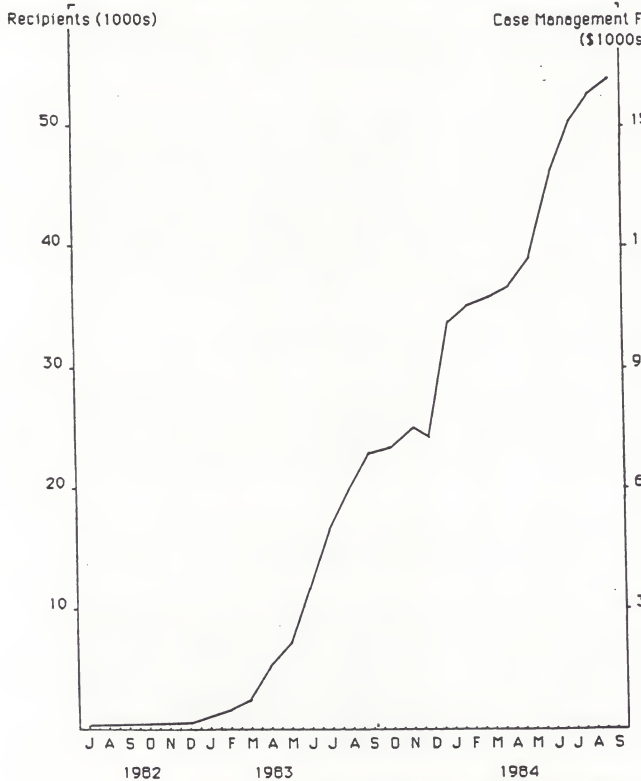
116. Department Analyst, Bureau of Medicaid Operations, Medical Services Administration, "Physician Primary Sponsor Plan Recipient Enrollment and Management Fee Summary," October 29, 1984; Health Maintenance Organization Section, Medical Services Administration, "Wayne County Health Maintenance Organization/ Capitated Ambulatory Plan Enrollment," October 31, 1984, from Planning and Evaluation Division, Office of Planning, Budget, and Evaluation, Michigan Department of Social Services, Health Care Alternative Within Title XIX, Quarterly Report, November 1984; Michigan League for Human Services, "Physician Primary Sponsor Plan Monitoring Project: Annual Report," October 1, 1984, p. 10.

EXHIBIT 4.7: PPSP RECIPIENT ENROLLMENT AND CASE MANAGEMENT FEE SUMMARY



Source: Department Analyst, Bureau of Program Policy, Medical Services Administration, October, 1984.

(1) The planning and testing of procedures and allocation of resources was not commensurate with the workload demand generated by the initiatives. For example, at certain times, less than ten percent of those telephoning actually got through to the Sponsor Specialists.

(2) This problem was heightened as the number of mailed brochures increased and prior authorization and other responsibilities were added to the Sponsor Specialist workload.

(3) The fact that many Medicaid physicians had not signed sponsor contracts created a pool of difficult-to-manage recipients who wanted to retain their non-sponsor physicians.

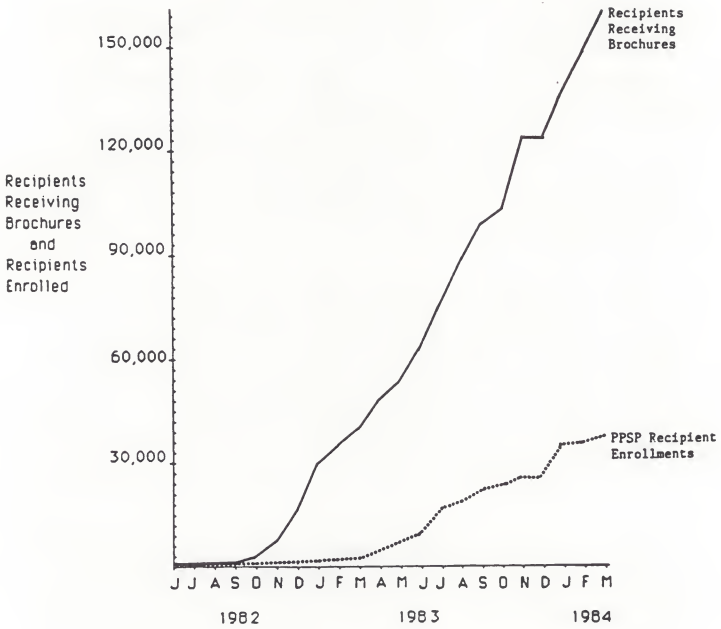
This does not mean that the early phase of recipient recruitment was not effective. Despite the shortage of resources, a large number, 36,516 recipients, were enrolled by March, 1984. In fact, a comparison of enrollments for May through August, 1983, with those for the same four-month period in 1984 shows that both approaches -- mandatory and voluntary -- generated about the same average number of enrollees per month (Exhibit 4.9). The central problem is that neither approach generated enrollments at the levels needed to achieve the original targets for PPSP.

There are good reasons to believe that more careful planning and application of resources -- that is, better management -- could have improved the enrollment results achieved under the earlier, more stringent, mandatory approach. For example, a larger staff of clerical personnel, more telephone lines, and more adept use of computers probably would have improved the results even if other resources were decreased to make the total commitment unchanged. However, the resource limitation and political constraints were probably so great that no amount of "better management" could have made the stringent mandatory enrollment process generate the large volume of enrollments that were expected originally.

The problem of too few resources created problems in the operations of the enrollment process that fostered a negative image of it among many PPSP recipients and physicians. For example, some recipients were assigned to inappropriate physicians. The existence of such problems made it easy to criticize the enrollment approach, but it is not evident that forced-choice per se is an unworkable approach. It simply was not fully successful as applied in that specific situation.

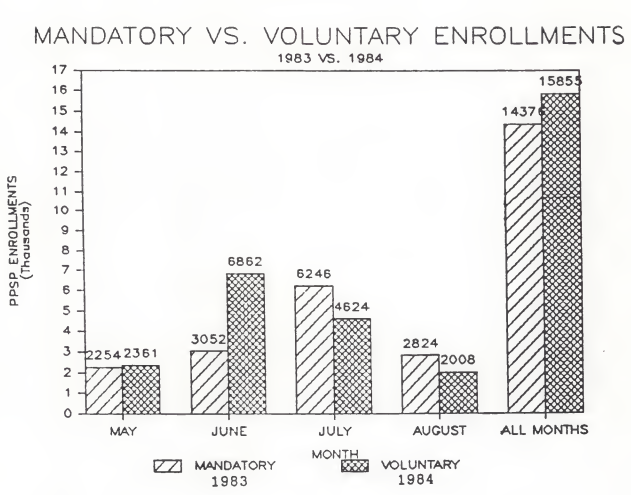
Exhibit 4.8

COMPARISON OF RECIPIENTS RECEIVING BROCHURES
(ESTIMATE) AND PPSP RECIPIENT ENROLLMENTS
(CUMULATIVE)



Source: Michigan League for Human Services, Monitoring and Evaluation Committee, "Minutes," December,1982, to March, 1984.

EXHIBIT 4.9


MANDATORY VS. VOLUNTARY ENROLLMENTS
1983 VS. 1984
PPSP ENROLLMENTS (Thousands)
17
16
15
14
13
12
11
10
9
8
7
6
5
4
3
2
1
0
2254
2361
3052
6862
6246
4624
2824
2008
14376
15855
MAY
JUNE
JULY
AUGUST
ALL MONTHS
MONTH
MANDATORY 1983
VOLUNTARY 1984

B. Success of Less Stringent Mandatory Enrollment

In the second phase -- April to September, 1984 -- the largest share of enrollments, almost 70 percent, were physician-assisted. The number of enrollments by point of origination is shown in Exhibit 4.10. During each month, the dominant mode was physician-assisted. As indicated, the number of physician-assisted enrollments decreased over time. Apparently, the initial surge of physician-assisted enrollments represented a backlog that is not indicative of the regular rate of physician-assisted enrollments.

Although based on a small sample, the monthly PPSP survey provides useful insight into recipient participation. For example, about three-fourths of the respondents who selected a sponsor chose a physician they were already seeing (71 percent in 1984 and 79 percent in 1983).(117) Depending on recipients' use of services before PPSP, this may indicate that enrollment does not necessarily represent a significant change in health care for a large percentage of the enrollees. If so, it is logical to question carefully whether sizeable changes in utilization and expenditures can be expected for all of this group. For example, sizeable changes could be evident because of the limitation to a single provider if the group's members were accustomed to using several providers independently before enrolling in PPSP.

C. Recipient Disenrollments from PPSP

The terms of the enrollment and participation agreement (see Chapter 2) include the recipient's right to change provider or disenroll from PPSP or another plan.(118) Prior to disenrolling, the recipient is urged to discuss any problems with his or her provider. If the cause for disenrollment persists, the

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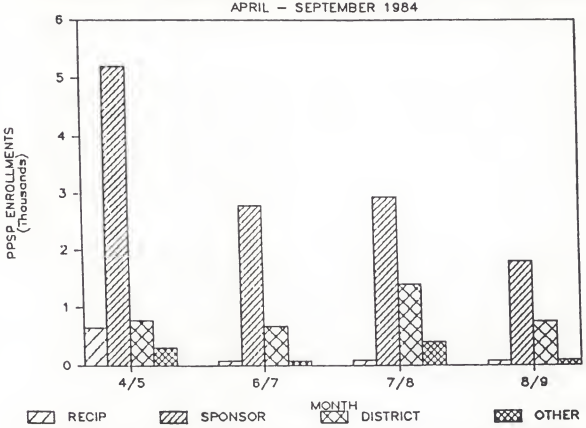
117. Medicaid Sponsor Program Monitoring Project, Michigan League for Human Services, PPSP Survey, on-going. Calculations from Michigan League for Human Services, Annual Report, 1983.

118. The MSA flowchart for PPSP and HMO disenrollment procedures is presented in Exhibit 2.4.

EXHIBIT 4.10

ENROLLMENTS BY POINT OF INITIATION

APRIL – SEPTEMBER 1984



Date	Recipient	Physician	District Office	Other	Total
4/10–5/25	657 (9.4%)	5219 (74.8%)	787 (11.3%)	316 (4.5%)	6979
5/29–6/22	78 (2.2%)	2785 (76.7%)	677 (18.7%)	78 (2.2%)	3618
6/25–8/17	89 (1.8%)	2941 (60.8%)	1407 (29.1%)	404 (8.3%)	4841
8/20–9/14	76 (3.9%)	1801 (52.1%)	761 (38.9%)	99 (5.1%)	1954
4/10–9/14	900 (5.2%)	11,963 (68.8%)	3632 (20.9%)	897 (5.2%)	17,392

Source: PPSP Steering Committee, December, 1984.

recipient is then asked to review the problem with a Sponsor Specialist. If the problem continues, the recipient may disenroll and then must select a different sponsor, HMO, or CAP.

An on-going but small resurvey of PPSP enrollees, which began in April, 1983 (described in the next section), has indicated that about ten percent of enrollees disenroll after three months. After six months, the disenrollment rate increases to 20 percent.(119) The following statement from a recipient typifies the problems of many recipients who want to discuss disenrolling from PPSP:

> The sponsor for the children has worked out really well. He's two blocks away and that's convenient for regular check-ups and lung X-rays. The doctor I picked is good because he's been my doctor for 13 years and he's quite familiar with my medical problems. Before my Medicaid was switched, I'd go to him for my X-rays and check-ups but if I didn't have bus fare and a breathing problem came up I'd go to the doctor's office nearest me for a shot but now I can't. To me the program's not fair or convenient. Sometimes I get sick for almost a week and can't breathe at night. When that would happen before I could just go to any doctor and now I can't. By my staying sick the cold builds up in my lung and makes the situation worse. I was sick on one occasion two weeks ago and couldn't get to my doctor so I went to one of the doctors I had went to before when I would have trouble breathing and asked if he would charge me later for a visit and he being aware of my problem gave me a shot and of course I haven't paid him yet but I know I'll have to. I really need my Medicaid back.(120)

An informal grievance procedure has emerged for enrollees. For non-emergency situations, PPSP enrollees can lodge any complaints with the Sponsor Specialists or with Legal Aid in Detroit. Information sent to PPSP enrollees alerts them to the problem-solving role of the Sponsor Specialists. However, the Medicaid Sponsor Specialists did not formally become "problem solvers" until March, 1984. For emergency situations, there is no formal or informal procedure for obtaining immediate satisfaction. In the MLHS enrollee surveys, about five

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119. Medicaid Sponsor Program Monitoring Project, Michigan League for Human Services, PPSP Survey, on-going. Calculations from Michigan League for Human Services, Annual Report, 1983.

120. Michigan League for Human Services, "Physician Primary Sponsor Plan Monitoring Project: Final Report," September 20, 1983, p. 15.

percent of the enrollees noted that they were not successful in obtaining the emergency room care which they needed.

The Monitoring and Evaluation Committee strongly urged the MDSS to establish a formal grievance system, one which would be officially responsible for responding to day-to-day grievances and emergency needs of recipients.(121) The MDSS began collecting formal PPSP complaints beginning in the spring of 1985. Both the complaints and their resolutions are recorded.(122)

4.3 CONCLUSION

Developing a workable and effective recipient enrollment process has been more difficult than originally expected. In combination with the lower than expected enrollment of sponsor physicians, this seems to explain, in large measure, why more recipients are not enrolled currently in PPSP or another plan.

While mandatory and voluntary enrollment strategies appear to have had about the same level of success in terms of enrollment numbers, the mandatory approach placed an inordinate strain on MSA resources and created negative attitudes toward PPSP among recipients and physicians. In particular, blind assignment of recipients to physicians and restrictions on non-assigned recipients created many more problems than they solved. It is likely that more gradual enrollment or the dedication of more administrative resources to enrollment would have averted some of these problems. We also suspect that Michigan's ambivalence about mandatory enrollment created problems that other more decidely mandatory or voluntary PCCM programs did not suffer.

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121. Chairperson, Monitoring and Evaluation Committee, telephone interview, April, 1985.

122. Project Director, Bureau of Program Policy, site visit interviews, May, 1985.

CHAPTER 5

ADMINISTERING PPSP

A key to the success of PPSP is the ability of the administering agency -- in this case MDSS -- to develop procedures to maintain physician and recipient involvement that is consistent with the terms of the sponsor contract and the more informal recipient agreement. This chapter focuses on the administration of PPSP during the first 26 months -- from July, 1982, to September, 1984 -- including the resources and the procedures that were used to enhance physician and recipient compliance with their responsibilities.

5.1 PROVIDE SUFFICIENT ADMINISTRATIVE RESOURCES

An annual expenditure of $0.8 million was projected for PPSP administration. This amount was about 4.3 percent of the additional cost of PPSP, but it did not include, for example, case management fees that were 54.8 percent of the projected added cost.(123)

In this case, administrative cost refers to resources -- mostly staff time, computer time, telephone, printing and mailing -- that were expended by MDSS to get PPSP started and continue its day-to-day operations. It does not include the regular cost of maintaining any group of recipients participating in Michigan Medicaid, be they PPSP enrollees or FFS recipients. It is merely the special administrative cost of PPSP: those requirements on MDSS resources that are in addition to those encountered in administering Medicaid recipients and providers under fee-for-service.

These special administrative expenditures are shown in Exhibit 5.1, where staff and computer costs are given for FY83 through FY85.(124) These expendi-

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123. See Chapter 2, pp.29-30.

124. Project Director, Bureau of Program Policy, Medical Services Administration; Department Analyst, Office of Support Services, Medical Services Administration; Office of Planning, Budget, and Evaluation, Michigan Department of Social Services, Health Care Alternatives Within Title XIX, Demonstration Project, Budget Proposal, Revised February, 1983.

EXHIBIT 5.1

SPECIAL ADMINISTRATIVE EXPENDITURES FOR PPSP

	Medicaid Sponsor Office (a)	MSA Staff	MSA Computer (b)	Total
10/82-9/83				
Dollar Amount	379,065	92,752	240,000	711,817
Staff (FTE)	10.0	2.50		12.50
10/83-9/84				
Dollar Amount	400,651	92,752	240,000	733,403
Staff (FTE)	10.0	2.50		12.50
10/84-9/85 (Projected)				
Dollar Amount	291,721 (c)	237,655	240,000	769,376
Staff (FTE)	6.0	7.25		13.25
Total				
Dollar Amount	1,071,437	423,159	720,000	2,214,596
Staff (FTE)	26.0	12.25		38.25

a. This total includes Sponsor Specialist Staff salaries and fringe benefits, office supplies and telephone, and the MSA/PPSP-related flyers and postage.

b. Computer costs include programming and running PPSP computer programs, as well as the proportional salaries of the systems staff.

c. This figure is an estimate. The MDSS budget for FY84 includes $163,400 for the Sponsor Specialist Staff salaries and fringe; it does not include the other costs involved in the Medicaid Sponsor Office. The remaining costs were estimated from the FY83 budget.

Source: Department Analyst, Office of Support Services, MSA; Project Director, Bureau of Medicaid Operations, MSA; OPBE, MDSS, Health Care Alternatives Within Title XIX, Demonstration Project, Budget Proposal, revised February, 1983.

tures increased annually -- three percent in the second year and five percent in the third year. In FY85, the changes in recipient enrollment methods also meant the redistribution of PPSP administrative responsibilities, staff, and expenditures. Funding for the Detroit-based Sponsor Specialists decreased and funding for the Lansing-based PPSP unit increased -- a $108,930 decrease versus a $144,903 increase.

The estimated actual MDSS PPSP special administrative expenditure in FY84 was about 11 percent less than initially projected ($733,403 versus $826,610), because staff expenditures were less than expected.

By September, 1985, the special administrative expenditure for PPSP totaled about $2.2 million for the first three years. On an annual basis, this administrative cost represents about two percent of the estimated expenditure for medical services to PPSP enrollees. If added to the statewide administrative cost rate of seven percent for Medicaid, the estimated administrative cost rate for PPSP would be about nine percent of annual service expenditures.

Exhibit 5.2 is a comparison of special administrative costs per PPSP enrollee from FYs 1983-85. Between FY83 and FY84, the special administrative cost increased only slightly while the number of enrollees more than doubled, causing the cost per enrollee to decrease by more than half (55 percent). If the number of PPSP enrollees increases as is expected, the special administrative costs per enrollee will be reduced to one-sixth of the initial FY83 cost per enrollee.(125)

In sum, the expenditures for the administration of PPSP are greater than those for fee-for-service. But, as the number of enrollees increases, it is reasonable to expect that special administrative costs will decrease as a percentage of the cost of care for all PPSP enrollees -- unless, of course, the cost of care decreases substantially.

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125. Projection based on current PPSP enrollment information. Department Analyst, Bureau of Medicaid Operations, Medical Services Administration, "PPSP Recipient Enrollment and Management Fee Summary," October 29, 1984.

EXHIBIT 5.2

PPSP ADMINISTRATIVE COSTS PER ENROLLEE
FROM 10/82 TO 9/85

	Administrative Costs	PPSP Enrollees	Admin. Costs Per PPSP Enrollee
10/82-9/83	$711,817	22,863	$31
10/83-9/84	$733,403	53,940	$14
10/84-9/85	$769,376	155,000 *	$5

* Projected.

Source: Department Analyst, Office of Support Services, MSA; Project Director, Bureau of Medicaid Operations, MSA; OPBE, MDSS, Health Care Alternatives Within Title XIX, Demonstration Project, Budget Proposal, revised February, 1983.

5.2 PROVIDE PPSP INFORMATION TO RECIPIENTS AND SPONSORS

Since the start of PPSP, Medicaid enrollees have called the Sponsor Specialists with questions reflecting lack of information and misunderstandings about PPSP. The Sponsor Specialists maintain files of these questions and concerns. In addition, the MLHS, through their regular contacts with recipients, Sponsor Specialists, and providers, document recipient questions and concerns in their monthly monitoring reports.

During the early years of PPSP, recipient misunderstanding included problems with enrollment procedures as well as with obtaining services once enrolled in PPSP. Some recipients were concerned about whether or not they could continue to receive Medicaid services from their regular physician. In addition, several recipients were confused by some HMO representatives who, while marketing HMOs to recipients, gave the impression that recipients must sign up with an HMO in order to maintain their Medicaid coverage. Recipients were also confused by an HMO information booklet, first distributed in March, 1984, which included the following erroneous notice: "Remember you must call 256-9344 to choose your HMO within seven days. If you do not call with your choice, the Sponsor Specialist will assign you to one of the six HMOs in this booklet."(126) Finally, some PPSP enrollees did not understand how to obtain authorization for referral care or emergency care under PPSP.(127) In an MDSS random survey of PPSP enrollees who had enrolled in early 1984, 20 percent of the respondents reported that they had not had enough information when they first enrolled in the program. Another 11 percent were not sure if they had been adequately informed. (See Section 6.3 of Chapter 6 for more details).

The MSA has responded to recipient misunderstandings and concerns through several communications, mostly pamphlets and information sheets. The Medicaid Sponsor Plan brochure was used to solicit enrollments and inform recipients

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126. Medical Services Administration, "Your Personal Guide to Health Maintenance Organizations, What You Should Know About HMOs, For Medicaid Card Holders," last page.

127. Project Director, Bureau of Program Policy, Medical Services Administration, site visit, June, 1984.

about PPSP and other delivery plan options.(128) It established the basis for what was to become an onslaught of questions directed to the Sponsor Specialists.

Exhibit 5.3 shows the results of a "Michigan Bell Busy Study" which took place between March 12 and March 16, 1984, a period of intensive Sponsor Specialist activity. The numbers presented in this chart reflect the calls which could not be completed because of busy telephone lines.(129) In the five-day period, 14,455 calls received a busy signal. Reportedly, this was one of the worst telephone bottlenecks that Michigan Bell has ever discovered. During this period, about 1,358 calls were taken, less than nine percent of the total calls made. Five hundred and fifty-five calls (41 percent) were enrollment-related (including changes). The 803 other calls were presumably related to computer match, MSA designation, and other means of unilateral enrollment of recipients not responding or selecting non-sponsor physicians. The average number of calls taken per day was 271.6; the number of calls taken per worker per day was 45.(130) Available information indicates that the phone lines were even busier during previous months. The average number of calls taken per worker per day between September, 1983, and February, 1984, was 48, seven percent more than the number per day recorded in the March study.(131)

In response to the problems that recipients were having because they could not reach the Sponsor Specialists to ask questions, the MSA developed a "Tel-Med" tape. Accessed by telephone, this tape summarizes PPSP: the wide variety

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128. Medical Services Administration, Medicaid Sponsor Plan, DSS-524, June, 1982, through February, 1984.

129. Supervisor, Medicaid Sponsor Office, memo to Bureau of Health Service Review Division Director, Medical Services Administration, RE: Michigan Bell Busy Study, May 18, 1984.

130. Supervisor, Medicaid Sponsor Office, memo to Bureau of Health Service Review Division Director, Medical Services Administration, RE: Michigan Bell Busy Study, May 18, 1984; The Sponsor Specialists (five staff and one supervisor) took 1358 telephone calls over a period of five days. Therefore, approximately 272 calls were taken per day and each specialist took about 45 calls per day.

131. Supervisor, Sponsor Specialist Staff, "Medicaid Sponsor Office Encounter Records Review," February, 1984.

EXHIBIT 5.3

MICHIGAN BELL BUSY STUDY (MARCH 12-16, 1984)

Day/Number of Calls Receiving Busy Signal

Time	Mon 3/12	Tues 3/13	Wed 3/14	Thur 3/15	Fri 3/16	Total
8-9 am	315	537	281	371	113	1617
9-10 am	271	211	266	157	225	1130
10-11 am	405	239	333	219	168	1364
11-12 am	592	401	350	368	175	1886
12-1 pm	358	500	102	394	158	1512
1-2 pm	406	431	399	246	310*	1792
2-3 pm	414	614*	497*	538*	223	2286*
3-4 pm	597	392	209	319	163	1680
4-5 pm	616*	275	113	113	71	1188
Total	3974	3600	2550	2725	1606	14,455

*Among the day's nine time periods, the largest number of calls occurred at this time.

of sponsors available, how to obtain care under PPSP, and how a recipient enrolls in PPSP. Recipients are made aware of this telephone number, a number different from that of the Sponsor Specialists, through sponsor physicians and other local sources. In the future, recipients will be made aware of this tape by the MSA. The MSA will include information about the Tel-Med tape and how it can be accessed, on an enclosure sent to recipients with their January, 1985, Medicaid card.(132)

Throughout 1983, the Monitoring and Evaluation Committee recommended that a post-enrollment pamphlet be developed and mailed to PPSP enrollees. The Committee played an advisory role when the MSA designed such a pamphlet. "You Are Enrolled with a Doctor Under the Medicaid Sponsor Plan" (see Attachment 2.3 for a copy) responds to many of the recipient concerns documented by the Sponsor Specialists and the MLHS. In a question-and-answer format, the pamphlet provides general information about PPSP and specific information on enrollment, the Medicaid card, use of delivered services, 24-hour access, procedures if sponsor is unreachable, prior authorization, referrals, specialists, disenrollment, and calling the Sponsor Specialists for more information. In March, 1984, the MSA began mailing the post-enrollment pamphlet to recipients. From March until September, 1984, an estimated 17,424 recipients received the pamphlet from the MSA.

In addition, the MSA was developing a newsletter to send to PPSP enrollees to further clarify issues as they arise. The MSA expected the newsletter to respond to some of the needs of the recipients who are unable to telephone the Sponsor Specialists.(133)

In sum, the PPSP information available to recipients since the first pamphlet, Medicaid Sponsor Plan, attempts to clarify the recipients' understanding of the various health care delivery options and, specifically, PPSP. A sys-

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132. Michigan Department of Social Services, "Notice to Recipients in Wayne County," 1985; Medical Services Administration, Tel-Med Recipient.

133. Department Analyst, Bureau of Program Policy, Medical Services Administration, site visit, June, 1984.

tematic analysis of the success of each of these clarification attempts has not been conducted.

In response to physicians' misunderstandings and problems, the MSA began a quarterly sponsor newsletter in the summer of 1984. The first issue covered the development of PPSP and the case management process for physicians. Future articles were to include questions and answers about PPSP and more information on the case management process.(134) Upon becoming sponsors, providers also receive written material from the MSA that spells out the sponsor's responsibilities and required procedures under PPSP.(135) The following discusses the specific MDSS procedures in place to ensure that sponsors meet their PPSP responsibilities.

5.3 ASSURE SPONSOR COMPLIANCE

The MSA developed several procedures to aid enforcement of the key sponsor contract responsibilities discussed in Chapter 2. These procedures are listed in the left column of Exhibit 5.4, which shows how each procedure relates to the six main contract provisions that MDSS and sponsors must meet. The discussion of procedures for administering contract provisions begins with the sponsor's responsibility to accept patient assignment.

A. Accept Patient Assignment

The MSMS believes that patient assignment is a crucial element of primary care cost containment under Medicaid. Wayne County physicians seem to support this view as indicated by survey data showing that patient assignment is one of PPSP's most attractive features. Physicians supported the concept of patient assignment to a single sponsor with the argument that this would ensure com-

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134. Publications Specialist, Bureau of Medicaid Operations, Medical Services Administration, site visit, June 1984; Michigan Department of Social Services, "Sponsor News," Summer, 1984.

135. Michigan Department of Social Services, "Physician Primary Sponsor Plan Quality Care for Medicaid Recipients," March, 1983.

EXHIBIT 5.4

MSA PROCEDURES TO ASSURE
COMPLIANCE TO SPONSOR CONTRACT PROVISIONS

MDSS PROCEDURES TO ENSURE COMPLIANCE*	SPONSOR CONTRACT PROVISIONS						
		Accept Role as Case Manager					
	Accept Patient assignment	Prior authorization	Medical Care Availability; 24-hour access	Render at least 50% care	Cost effective financial management	Quality of care	$3 Management fee
Unique sponsor & enrollee identifiers	X	X					X
MDSS Medicaid bulletins & letters	X	X	X				
Addendum A					X		
MDSS Monitoring Reports							
to sponsors	X				X		X
in-house	X						X
MDSS Contact	X	X	X		X	X	X
Monitoring & Evaluation Committee		X	X			X	

* Each MSA procedure grouping consists of several components, which are specified in the text of Chapter 5.

prehensive knowledge of their patients' medical care.(136)

MSA has used Medicaid bulletins and PPSP information letters to explain patient assignment procedures and the signals to look for on the recipient's Medicaid card. The bulletins explain each of the three signals on Medicaid cards and how they relate to identification of an enrollee's sponsor. The central MSA bulletin (Number 5310-82-03), effective July 1, 1982, was titled "Implementation of the Physician Primary Sponsor Plan in Wayne County." It explained how to identify a recipient who has chosen a sponsor and defined Medicaid program requirements for all providers rendering care to a Wayne County recipient enrolled in PPSP. The bulletin described how the PPSP is identified on the Medicaid card in the following way:

> Beginning July 1, 1982, the Medicaid ID Card will identify a recipient who is enrolled in the sponsor plan by Level of Care Code 12. The message, "Physician Primary Sponsor," will also be printed on the right side of the card. The name and telephone number of the sponsor for each family member will be printed under the recipient's name on the card.
>
> . . . The recipient must go to the sponsor indicated on his Medicaid ID card for all his primary medical care, except dental, vision, podiatric, and chiropractic services.(137)

In this way, the sponsor responsibilities involved in patient assignment are clearly explained to sponsors.

To help monitor patient assignment, MDSS developed two new reports which list PPSP enrollees by sponsor to ensure that sponsors know who is in their PPSP caseload. Starting in July, 1982, on a monthly basis, MDSS sent to sponsors a listing (FM 081) of the PPSP enrollees added and deleted from the sponsor's caseload. However, it was discovered quickly that an up-to-date list of PPSP enrollees in their caseloads would be less confusing. This type of list (called the FM-150) was requested in late 1982, and in the fall of 1983, MDSS began gen-

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136. Goldberg, T., "Survey of Physicians Regarding the Medicaid Primary Sponsor Plan," 1984.

137. Michigan Department of Social Services, Medical Assistance Program Bulletin, No. 5310-82-03, July 1, 1982.

erating it on a quarterly basis.(138)

Shortly thereafter, another computer report, the FM-085, "Monthly Master Listing," was initiated. It supplanted the two earlier reports because it includes the total number of PPSP recipients in a sponsor's caseload that month and detailed recipient information, such as name, Medicaid ID number, and date enrolled in PPSP. The MSA sends monthly FM-085s to each sponsor physician to verify the accuracy of case management payments.(139) Approximately 1,200 FM-085 reports (depending on the number of sponsors) are generated and mailed on a monthly basis.

B. Accept Role as Case Manager

One of the themes which runs throughout the sponsor contract is the sponsor's responsibility to assume the role of case manager. After accepting patient assignment, the three most basic case management responsibilities are prior authorization, 24-hour access, and rendering of at least 50 percent of care.

Prior Authorization. One of the primary changes for physicians under PPSP involves the requirement for "prior authorization" of non-emergency medical care not provided by sponsors or their immediate staffs. According to the PPSP contract, the sponsor must give prior authorization for all medical care rendered outside of the sponsor's domain. This includes: specialist, X-ray, laboratory, and in-patient and out-patient hospital care. Also, sponsors must authorize drug prescriptions, unless a specialist to whom the enrollee is referred writes the prescription.

As in the case of patient assignment, the MSA used Medicaid bulletins, PPSP information letters, and PPSP information brochures to explain prior authoriza-

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138. Office of Support Services, Michigan Department of Social Services, FM-081, Recipient Enrollment List and FM-150, Provider Master Listing.

139. Office of Support Services, Michigan Department of Social Services, FM-085, Monthly Listing of Enrollees per Sponsor; Department Analyst, Office of Support Services, Medical Services Administration, telephone interview, September, 1984.

tion procedures to sponsors. The "Medical Assistance Program Bulletin" is specific about the method for referral care:

> The sponsor is responsible for the method (e.g., letter, telephone call) he/she uses to refer an enrolled recipient to another provider for medical treatment. Whatever method is used, the provider to whom the recipient has been referred and the sponsor must document the referral in the recipient's medical record. The sponsor also determines, while consulting with the other provider, the time period of the referral.(140)

The specialist to whom the enrollee is referred may then "prescribe/order most services from other providers (e.g., pharmacy, laboratory, radiology) . . ." without further authorization from the sponsor. In addition, the providers for whom a PPSP enrollee does not need prior authorization are also listed in the "Medical Assistance Program Bulletin."

The MSA's billing/payment process is the one way in which prior authorization is enforced. In order to receive payment for delivered services, the referred provider must submit a claims form to the MSA. Information on the claims form includes: the recipient's Level of Care code, status of enrollment in a health care delivery program, and the sponsor's name, ID number, and address (if applicable). Therefore, for a physician (sponsor or specialist) to receive payment for services, the claims form must be complete and appropriate. If the specialist submits an inaccurate sponsor Medicaid ID number for the PPSP enrollee or the enrollee's sponsor, the MSA computer system is programmed to reject the bill.(141)

Despite MSA efforts, the procedures that were developed to assure compliance with prior authorization could break down. For example, non-sponsor physicians may contact the sponsor for authorization after providing care to a PPSP enrollee instead of before, or a non-sponsor could simply forge the

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140. Michigan Department of Social Services, Medical Assistance Program Bulletin, No. 5310-83-03, 1983, p. 2.

141. Office of Support Services, Michigan Department of Social Services, Remittance Advice; Department Analyst, Office of Support Services, telephone interviews, September, 1984.

authorization by recording the enrollee sponsor's identification number on the Medicaid claim. While there is no evidence of widespread abuse, there are only minimal safeguards against it.

24-Hour Access. Under PPSP, an enrollee's access to medical care may be jeopardized because the sponsor physician is not readily available to provide or authorize care. This is more likely to be a problem for those seeking care during off hours. In contrast, under fee-for-service, a recipient has the option of contacting several physicians, thus minimizing the problem of a single physician's non-availability.

Although MSA developed guidelines early in PPSP implementation, procedures to monitor and ensure compliance with the 24-hour access guidelines were not established until December, 1983. Since March, 1984, the MSA has sent a letter which specifically describes the 24-hour access responsibilities to all prospective PPSP sponsor physicians. In the letter, the MSA is very clear about acceptable 24-hour access telephone number arrangements: one phone number which is answered during office hours by the doctor's office staff and at other times by an answering service which can contact the doctor or another medical practitioner whom the doctor has designated to consult with the recipient during the sponsor's absence.(142)

In March, 1984, as part of its regular monitoring, the MLHS began calling sponsors at odd hours to determine if they were complying with the 24-hour availability provision. Each month the MLHS telephoned 20 PPSP sponsors, plus those sponsors who prompted enrollee complaints during the previous month. Overall, approximately 30 percent of the sponsors were not in compliance with the 24-hour availability provision.(143) Sponsors found to be out of compliance

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142. Michigan Department of Social Services, 24-hour access letter to sponsors.

143. Michigan League for Human Services, "Proposal to Monitor 24-Hour Access," December, 1983.

were notified and referred to the sanctions in the sponsor contract.(144) As of September, 1984, all but two physicians responded to this letter by meeting the 24-hour availability guidelines. The two physicians not in compliance were put under review by the Peer Review Committee.

Render at least 50 Percent Care. According to the sponsor contract:

> The sponsor shall personally render at least 50 percent of the primary care physician procedures billed under the medical assistance program. Any primary care provided by physician assistants, nurse practitioners, or similar staff who are directly supervised by the sponsor shall be considered as personally rendered by the sponsor for the purposes of this paragraph. The sponsor also agrees to respect the rights of recipients as set forth in the departmental publication entitled "Your Rights and Responsibilities Under the Michigan Medicaid Program" and any amendments thereto.(145)

As of late 1984, the MSA had not implemented procedures to monitor and ensure physician compliance with this provision.

C. Cost-Effective Financial Management

Cost-effective financial management was one of the basic purposes of PPSP, from the standpoint of the MDSS and the U.S. Department of Health and Human Services' Health Care Financing Administration. The MDSS discovered a fine line between implementing rigorous policies to achieve cost-effective financial management and maintaining PPSP's appeal to physicians. Therefore, the MDSS applied cost-effective financial management standards only for those sponsors with recipients who had the highest utilization levels.

In November, 1983, the MSA implemented an automated data report to monitor

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144. Monitoring Project, Michigan League for Human Services, letter to sponsors regarding 24-hour access problems; Monitoring Project staff, telephone interview, March 1984. Letters are sent to sponsors after three formal complaints are made by recipients. Calls and follow-ups are done by the Sponsor Specialist Unit and the Monitoring Project staff.

145. Medical Services Administration, Michigan Department of Social Services, "PPSP Sponsor Contract," August 19, 1983, p. 3.

high utilization by PPSP enrollees. This report (the FM-140 or "Physician Sponsor Utilization Report") gives a quarterly breakdown and year-end total of services rendered to each recipient who greatly exceeds the average.(146) The following is a list of items in the report:

- o total payments Medicaid
- o no. different providers
- o physician payments
- o no. different physicians
- o physician ambulatory payments
- o no. physician ambulatory visits
- o physician office visit payments
- o no. physician office visits
- o no. outpatient hospital encounters, general
- o no. hospital discharges, general
- o no. inpatient hospital days
- o inpatient hospital payments and
- o pharmaceutical summary (includes average number RX/physician visit).

Between November, 1983, and September, 1984 the MSA mailed 3590 FM-140 reports -- an average of 359 per month. Over this period, the number of FM-140s increased as PPSP grew but the percentage remained less than two percent of total PPSP enrollees. In August, 1984, for example, 825 reports were sent out to physicians.(147) The purpose of the report, according to its cover letter from the MSA, is to "assist [the sponsor] in managing the care of [the sponsor's] en-

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146. Office of Support Services, Michigan Department of Social Services, FM-140, Quarterly Report of Services Rendered to PPSP Enrollees. A sample report and explanatory letter are provided in Attachment 5.1.

147. Project Director, Bureau of Program Policy, Medical Services Administration, telephone interview, October, 1983.

rolled recipients."(148)

The MSA has made no formal attempt to sanction sponsors who receive numerous FM-140 reports; the report is intended merely to aid sponsors' cost-effective financial management of their enrollees' utilization. MSA has not yet developed a threshold which defines "too many" FM-140 reports mailed to one sponsor. Rather, MSA has sent these reports to physicians expecting that the sponsors will voluntarily use them to manage enrollees' use of medical services. For sponsors receiving FM-140s, there is an option to obtain additional information about their PPSP enrollee's past years' Medicaid history. This report chronologically lists specific pharmaceuticals, labs, X-rays, and specialists and the names of corresponding providers.(149)

The original plan -- the one included in the sponsor contract -- called for two analytical reviews of sponsors' PPSP enrollees' utilization and expenditure patterns.(150) The first, which has become operational, is a pre-contract procedure to identify sponsor physicians who are likely to exceed cost standards.(151) These sponsors may get on-notice letters with their contracts after review of class group average cost comparison data by a peer review advisory committee.(152)

The second analytical review, called the 95th percentile cost standards review, has not become operational.(153) It was expected to identify sponsors

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148. Michigan Department of Social Services, cover letter to PPSP Sponsor Contract.

149. Office of Support Services, Michigan Department of Social Services, FJ-461, Recipient Claims Listing, Detail Report.

150. See Addendum A, PPSP Sponsor Contract, Attachment 5.2.

151. Worksheet Used for Sponsor Contract, Addendum A, Part II, Calculations; FK-095 Analysis Sheet, Physician Sponsor Applicant; Physician Sponsor Plan Monitoring Data, Level I, II, III, criteria; FK-095, Summary Profile Report, Provider.

152. Medical Services Administration, on-notice letter to specified sponsors.

153. Michigan Department of Social Services, "PPSP Sponsor Contract," Addendum A, Part I.

whose standardized average cost per recipient is above the 95th percentile for all sponsors with a similar caseload. The 95th percentile standard has not been applied for three reasons:

- the caseloads of sponsors have not become large enough to support good comparative analysis;
- programming and computer support needed to initiate the analysis for applying the cost standards has been lacking; and
- the 95th percentile method does not -- in the opinion of MDSS legal experts -- provide a basis for excluding physician sponsors from further PPSP participation.

D. Quality of Care

While quality is an underlying concern for any plan of medical care delivery and financing, the sponsor contract does not include special provisions for quality assurance under PPSP that are in addition to those governing Medicaid generally. In short, there is no special formal system of quality assurance under PPSP.

Instead, there is reliance on standard Medicaid peer review as well as the less formalized systems of taking and investigating PPSP enrollees' complaints about quality. In the latter, PPSP enrollees can lodge any complaints with the Sponsor Specialists or with Legal Aid in Detroit. PPSP enrollees may also voice any dissatisfaction with their sponsors to the Wayne County Sponsor Specialist or the PPSP Unit in Lansing.(154) Since March, 1984, information sent to PPSP enrollees has been alerting them to the problem-solving role of the Sponsor Specialists.

Before PPSP was implemented, the Better Health Care Coalition, a recipient advocacy group, proposed a system for quality assurance to the PPSP Steering Committee. The proposed system has the following four components.

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154. Chairperson, Monitoring and Evaluation Committee, telephone interview, March, 1985.

I. The Primary Care Physician must submit to MDSS as part of patient management the written procedures the sponsor has for medical care availability, emergency access, and services available.

II. The Primary Care Physician shall assure the maintenance of a clinical record in accordance with accepted professional standards and practices.

III. The Primary Care Physician shall make available to recipients the appropriate preventive health education, screening, and information about available services.

IV. The MDSS shall establish a Quality Assurance Program which will assure a consistent rendering of high quality health care services through the use of monitoring techniques. This must include a formal structure created for the purpose of monitoring, reviewing and evaluating the quality of health services provided, and appropriateness of health care resources utilized.(155)

To date, such a quality assurance system has not been implemented.

E. Three-Dollar Case Management Fee

The MSA pays sponsor physicians three dollars per month for each PPSP enrollee in their caseload. The MSA expected this fee to provide incentive for sponsors to carry out their responsibilities. The MSA has two automated reports to ensure accurate and prompt fee payments to sponsors. The FM-051, "Provider Master Listing" gives name, CAP or sponsor, license number, address, telephone, willingness to accept new recipients, group practice name, languages spoken in the office, and the physician's specialty.(156) The MSA uses the FM-051 to verify the sponsor's eligibility to receive case management fees. The amount of the fee is derived from records of PPSP caseload size.

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155. Mahaffey, Maryann, Better Health Care Coalition, letter to the Director of the Physician Primary Sponsor Plan Steering Committee, May 3, 1982. See Attachment 5.3 for details.

156. Office of Support Services, Michigan Department of Social Services, FM-051, Provider Master Listing.

Finally, the MSA sends a monthly summary of payments to each active Medicaid physician. This "Remittance Advice" includes the amount paid to sponsors for their monthly case management fee.(157)

5.4 CONCLUSION

One of PPSP's most difficult administrative tasks has been to establish an accurate and timely understanding of program requirements and procedures among recipients and providers. While brochures and letters are valuable, they are not enough. Nothing works as effectively as personal contact, providing it is accessible to those who need assistance. Michigan's, unhappy experience with inadequate staffing of its PPSP hotline underscores the importance of this point. The remainder of this chapter suggests that PPSP administration requires a great deal of coordination and information to work smoothly. To date, MSA has paid a great deal more attention to using its information generating and reporting capability to support physicians in controlling recipient utilization than in monitoring and influencing physician behavior under PPSP.

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157. Office of Support Services, Remittance Advice.

CHAPTER 6

STATUS OF IMPLEMENTATION AND PROGRESS TOWARD ACHIEVING THE PPSP OBJECTIVES

The design and objectives of PPSP were described in Chapters 1 and 2, including the measurements that would indicate progress accomplishing each objective. In Chapters 3-5, the process of starting PPSP was examined, focusing on physician and recipient marketing and recruitment and MDSS administration. Overall, the implementation of PPSP has lagged behind Michigan's original timetable and below the original targets for key elements like the number of primary care physicians under contract and the number of enrolled recipients. In comparison to the reported results from other states, however, it appears that Michigan is a leader in PCCM implementation, having enrolled more recipients and contracted more physicians than any other state.

This chapter assesses the early effects of the PPSP by first recapping the current status of implementation and then turning to progress toward meeting each PPSP objective. Admittedly, the discussion of implementation status focuses primarily on the problems Michigan encountered. Since many states are facing similar difficulties and have had less success than Michigan, we believe that it is important to examine PPSP implementation critically to help identify problems that other states may avoid and to help find workable solutions for unavoidable difficulties.

6.1 LESS IMPLEMENTATION, LESS IMPACT

To date, the most fundamental finding about PPSP implementation is that recruitment of physicians, enrollment of recipients, and development of PPSP administrative procedures has occurred more slowly than expected. The original timetable presented to the legislature in October of 1981 called for recruiting thousands of physicians and enrolling hundreds of thousands of recipients by December, 1982. As of September, 1984, approximately 1,260 physicians and 54,000 recipients were participating in PPSP, well under one-half of the original targets for both groups. Since projected aggregate savings and other

expected results are dependent on the level of implementation, the lag in implementation undoubtedly undercuts the level of benefits that can be achieved.

There are several reasons for implementation having been less complete than expected. The first and most obvious is that the original objectives and implementation schedule were overly ambitious, particularly considering the scope and complexity of the change involved in starting PPSP. In their eagerness to contain costs, legislators, state physician association representatives, and MDSS officials established timetables and expected levels of benefits that were implausible given past experience applying PPSP design concepts in Medicaid and the resources allocated to the project.

The responsibility for this over-ambitiousness is shared at the federal level because of the emphasis on achieving savings quickly, rather than developing a workable PCCM system that operates at less cost than fee-for-service. While these are not incompatible aims, the pursuit of end results alone generally implies that perfecting the means to these end results goes relatively unattended.

In retrospect, it seems that the timetable and resource requirements for achieving results were more of a problem for PSPP implementation than was the level of benefit that was projected. It seems obvious that the recession and specter of a state revenue shortfall created pressure to underestimate the time and resources that would be required to gain savings from PPSP. The lesson for other states is that significant results should not be expected soon after starting a PCCM and that planning and implementation are more time-consuming and resource-intensive than may be expected.

Another issue was the adequacy of administrative resources for combined implementation and continuing operation. Were enough made available? The cost of making change is generally greater than expected. Perhaps reflecting the same kind of pressure for results that spawns unrealistic schedules, implementation costs are often underestimated. This has the positive effect politically of making the proposal seem more effective or efficient, but it can mean sacrificing all or part of the end result if true implementation costs are avoided. For

PPSP, there was not an implementation budget per se, so implementation and administration competed for the same resources. After the first few months, continuing administration costs, such as for managing recipients with MSA designation, began absorbing resources that were needed for marketing unenrolled recipients, thereby making it harder to advance implementation.

If realistic objectives and sufficient resources had been present, there would have been some remaining tactical problems with PPSP implementation. The most basic, in our opinion, was the lack of a workable approach to managing the interrelated aspects of physician recruitment and recipient enrollment. At first, these two activities proceeded on separate tracks, causing difficult logistical problems, such as a backlog of recipients who wanted to enroll with a non-sponsor primary care physician. In retrospect, it seems that these two key functions should have been managed more interdependently, perhaps targeting initial recipient enrollment efforts first at patients of physicians with sponsor contracts.

The next most pressing tactical problem concerned the procedures for both physician and recipient recruitment. Apparently, it was assumed that all existing Wayne County Medicaid primary care physicians would sign sponsor contracts, so the physician marketing effort was targeted broadly at all primary care physicians to increase the number in Medicaid. Given the subsequent difficulty of gaining signed contracts with existing Medicaid primary care physicians, it is apparent that physician marketing should have been more narrowly focused on this group from the beginning.

As for recipient enrollment, it seems clear that the strict mandatory approach employed in the first 12-20 months produced many difficulties and probably should not have been tried without more careful development and testing. The more recent, less stringent, approach does not seem to cause the same problems, but the monthly rate of enrollment remains far lower than originally projected (albeit still well ahead of most states).

It is not apparent today that the problems encountered in starting PPSP have been resolved. There is no promising approach to attract more primary care

physicians to PPSP and the problem of enrolling recipients at a pace fast enough to reach original targets in the near future still remains.

Despite a somewhat troubled implementation, PPSP still is the largest operating private physician-based Medicaid PCCM in the nation. As such, it provides a setting from which lessons for other states and the nation can be learned. To the extent that evaluations have shown that PPSP achieves valued objectives, such as savings, without undermining (and perhaps improving) quality of care, the importance of improving the technology for implementing and administering a PCCM has risen.

Chapters 3-5 detail the difficulties which Michigan faced in recruiting physicians, enrolling recipients, and administering the program. Upon reflection, these difficulties indicate that PCCM implementation in Michigan has been (1) more complex, and (2) more costly, and (3) has involved more untested approaches than anyone originally had expected.

Complexity. The planning and development of PPSP have involved many organizations and individuals in Michigan as well as officials at the federal level. As such, the lines of authority, accountability, and communication form a large, complex network, further complicated by the diverse special interests and agendas of the participating parties (see Chapter 1 for the history of PPSP). While this may be unavoidable because of the general complexity in health care system delivery and finance, it undoubtedly has affected implementation by making coordination more time-consuming and more difficult to achieve.

This complexity also appears in the number of offices which are involved in implementing and administering PPSP within the MDSS. As Exhibit 2.3 in Chapter 2 shows, a variety of MDSS and MSA units are directly or indirectly involved in administering PPSP. Within MSA, the PPSP unit is responsible for basic PPSP operations, yet other parties control key functions or have substantial authority over MSA's handling of PPSP.

Costs. Exhibit 5.1 in Chapter 5 shows that the administrative outlay for PPSP exceeds that required under fee-for-service. Furthermore, the PPSP ad-

ministrative resources have been stretched thinner and thinner as the cost per enrollee has steadily declined since the beginning in July, 1982. In addition, the original estimates of required resources were apparently too low, especially given the various implementation problems which resulted from understaffing of key tasks at critical times (see Chapter 4).

Untested Approaches. The case management concept is new in Medicaid, and its success requires that Michigan accomplish a series of very difficult tasks. These include convincing independent-minded physicians to enter into a contractual agreement with the state government, convincing recipients to reduce their freedom of choice among providers, and convincing both groups to adopt new behaviors and adapt to new procedures designed to affect the costs and appropriateness of medical care. Since few proven approaches to the required tasks had been developed previously, Michigan was forced to innovate and experiment at each step.

Some of the innovations were clearly unsuccessful. For example, the early forms of stringent mandatory recipient enrollment, which were eventually abandoned, produced inconvenience and confusion for many who were involved. Other strategies, such as the untargeted recruitment of physicians, were less troublesome but not particularly effective. Some innovations, such as physician-initiated recruitment of recipients, were relatively successful and continue to be effective. Finally, some innovations seem to be workable but there is room for improvement. One example might be the procedures for assuring that sponsors prior authorize specialist care.

Considering these difficulties, it is not surprising that the largest share of the Medicaid program in Wayne County continues to operate as it did before PPSP implementation in July, 1982. As of September, 1984, most physicians (about 63 percent) continued to operate at least partially under the traditional fee-for-service reimbursement system. Furthermore, most recipients (62 percent) continued to receive Medicaid under the traditional system with no case manager (sponsor) identified on their Medicaid cards. Accordingly, it would be highly inappropriate to judge the results of Michigan's implementation of Primary Care Case Management (i.e., the PPSP) solely against the original goals established

in 1981. Since a smaller than expected percentage of physicians and recipients are participating in PPSP, it is unreasonable to expect the full measure of results originally predicted. The hoped-for decreases in aggregate utilization and expenditures, for example, are simply impossible to achieve with the 54,000 recipients enrolled.

However, it is appropriate to assess the results achieved through the participation that has been accomplished and to see if this beginning has moved Michigan any closer to achieving the four objectives of PPSP. This chapter presents preliminary findings about the PPSP, reflecting our best understanding with readily available information.

6.2 OBJECTIVE #1: CONTAIN COSTS WHILE PAYING EQUITABLE FEES

Until very recently, the information on cost savings resulting from PPSP was limited to findings from small sample studies. In addition to the problem of incomplete implementation discussed above, Michigan is hampered by the traditional lag between medical service delivery and availability of reliable data about those services. As described in Chapter 2, the PPSP was expected to produce a net savings in Medicaid expenditures of about $69 per enrollee per year -- predicated on 1982-83 utilization statistics for the continuously eligible portion of the Wayne County Medicaid population. Assuming this average savings for all but those who are institutionalized or join HMO or CAP, the total annual savings would be about $19.7 million per year. These savings would result from changes in utilization -- mostly the use of inpatient hospital services. Additional savings would be expected from HMO and CAP enrollment.

This level of savings would compare very favorably to other especially effective Medicaid cost containment initiatives implemented by Michigan. According to a list of savings for 1982-83, shifting outpatient reimbursement from allowable costs to fee-for-service and imposing a limit on hospital operating costs produces greater estimated savings than PPSP, $26.8 million and $21.9 million, respectively. Though slightly less than PPSP, the savings produced through three-year rebasing of hospital rates, $18.2 million, is the only other initiative with annual savings over $12 million; and most initiatives produce

more marginal decreases, generally less than $5 million. Thus, it appears that PPSP has the potential to produce noteworthy Medicaid savings.

To assess savings and related changes in service utilization, MSA tracked, on a quarterly basis, a small group of enrollees and MDSS conducted a major three-year evaluation sponsored by HCFA. The results of these two efforts are presented in this section.

A. Monitoring

The MSA monitoring produced estimates of total payments and 13 other categories of use and payment expected to be affected by PPSP.(158) These estimates were based on a very small sample -- about 60 each of PPSP enrollees and FFS recipients -- for the three quarters preceding and the two following PPSP start-up. The sample was much too small to include enough instances of hospitalization to support even the most tentative finding about inpatient hospital use and costs. In some areas, like physician services, the data may be more indicative, but still not sufficient to support generalizable findings. Furthermore, baseline figures (pre-PPSP) for the PPSP sample were generally higher than for the control group (suggesting non-comparability) and the samples varied slightly from month to month due to fluctuations in Medicaid eligibility.

Exhibit 6.1 shows average pre-PPSP and post-PPSP utilization and expenditures for a group of PPSP enrollees and a comparable group of Medicaid recipients not enrolled in PPSP. Both groups showed lower utilization after PPSP was introduced, but the decline for the PPSP group was larger. For example:

- The number of different physicians seen by the PPSP group declined considerably, a 46.9 percent reduction, compared to a 10.8 percent reduction in the control group. This is the effect expected for the PPSP program.

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158. The data reported here are taken from "Physician Primary Sponsor Plan Utilization Trends Analysis: Methodology and Findings," an MDSS document date August 1, 1984.

EXHIBIT 6.1

SUMMARY OF PRE- AND POST-PPSP UTILIZATION AND EXPENDITURE DATA FOR PPSP AND NON-PPSP MEDICAID RECIPIENTS[1]

	Pre-PPSP Quarterly Average	Post-PPSP Quarterly Average	Percentage Change
Total Payments			
PPSP group	$256.24	$115.93	-54.8
Control group	279.06	156.23	-44.0
Total Payments Minus Inpatient Hospital Payments			
PPSP group	$166.30	$ 89.42	-46.2
Control group	121.28	100.34	-17.3
Number of Different Providers			
PPSP group	3.28	2.05	-37.5
Control group	2.41	2.23	- 7.5
Physician Payments			
PPSP group	$ 73.23	$ 40.57	-44.6
Control group	55.20	43.34	-21.5
Number of Different Physicians			
PPSP group	1.507	.802	-46.9
Control group	.977	1.87	-10.8
Physician Ambulatory Payments			
PPSP group	$ 24.56	$ 12.10	-50.5
Control group	13.94	12.47	-10.5
Outpatient Hospital Encounters			
PPSP group	.708	.127	-82.1
Control group	.237	.141	-40.8
Pharmacy Payments			
PPSP group	$ 31.37	$ 27.23	-12.9
Control group	26.65	26.06	- 2.2
Number of Different Pharmacies			
PPSP group	.846	.705	-16.9
Control group	.712	.764	+ 7.3
Total Prescriptions			
PPSP group	4.02	3.29	-18.2
Control group	3.02	2.96	- 1.8
Number of Scheduled/ Abusive Rx			
PPSP group	.787	.542	-31.1
Control group	.616	.837	+36.0
Number of Laboratory Procedures			
PPSP group	3.734	1.54	-58.7
Control group	1.876	1.56	-17.0
Number of Radiology Procedures			
PPSP group	.495	.331	-33.0
Control group	.299	.348	-16.4

[1]Source: Michigan Department of Social Services, "Physician Primary Sponsor Plan Utilization Trends Analysis: Methodology and Findings," August 1, 1984.

- There was a large decline in the number of different providers seen by the PPSP group -- a predicted effect. The control group indicates a decline of only 7.5 percent vs. 37.5 percent in the PPSP group.

- Outpatient hospital encounters among the PPSP group declined twice as much as those among the control group -- 82.1 percent vs. 40.8 percent.

- The use of lab procedures by the PPSP enrollees continued to decline tremendously. The PPSP quarterly average declined by 58.7 percent whereas the decline for the control group was only 17.0 percent.

- The average number of radiology procedures for the PPSP group declined by 33.0 percent, against 16.4 percent for the control group.

These lowered utilization rates led, as hoped, to lower expenditures for the PPSP group relative to the control group. For example:

- Total quarterly average payments for the PPSP group declined from $256.24 for the three pre-PPSP quarters to $115.93 for the two post-PPSP quarters (a 54.8 percent reduction). For the control group, average quarterly payments declined from $279.00 to $156.23 (a 44.0 percent reduction). The reduction is greater for the PPSP enrollees than the control group.

- When inpatient hospital payments are excluded from the analysis of total payments (and they should be, given the brevity of the periods being analyzed and the small sample sizes), the difference between the PPSP sample and the control sample is much more dramatic. The average quarterly total payments for the PPSP group declined from $166.30 to $89.42 (a 46.2 percent reduction), while for the control group they declined from $121.28 to $100.34 (17.3 percent).

- Overall, there was a decline in physician payments -- 44.0 percent for the PPSP group vs. 21.5 percent for the control group. Physician ambulatory payments declined by 50.5 percent for PPSP enrollees and only 10.5 percent for the control group.

- Inpatient hospital expenditures for the PPSP group declined by 71 percent as opposed to a 77 percent decline for the control group. The control group started out with a much higher baseline average for the pre-PPSP period than did the PPSP enrollees. There were no incidents of utilization of inpatient hospital services for the sampled group of PPSP enrollees for two of three quarters studied -- this tends to reduce the validity of the findings. A larger sample size of 1,000 or 2,000 would have to be studied to get a better indication of utilization trends, because use of inpatient hospital services is so rare to begin with.

- There was a 12.9 percent reduction of the pharmacy payments for the PPSP group and a 2.2 percent reduction for the control group. The post-PPSP average for the PPSP group was higher than that for the control group -- but the baseline average for the PPSP group was higher than that of the control group. For the number of scheduled/abusive Rx, there was a decline of 31.4 percent for PPSP enrollees vs. an increase of 36 percent for the control group.

It is worth noting here that in all but two categories, the control sample showed decreases that are similar but less dramatic than the PPSP sample's. For example, total payments decreased 44 percent for the control group and 55 percent for PPSP. This implies that other initiatives or changes in the Medicaid environment were generating effects similar to those expected of PPSP. This seems particularly evident for total payments, number of providers, physician payments, number of physicians, physician ambulatory payments, outpatient encounters, pharmacy payments, total prescriptions, laboratory procedures, radiology procedures, and total payments minus inpatient hospital payments. Although never as great, percentage decreases in these categories for the control sample were consistent with those of the PPSP sample.

In 11 of the 14 use and payment categories, the post-period quarterly averages were rather similar for the PPSP and control samples (plus or minus 12 percent). For example, the post period average for physician ambulatory payments was $12.47 for control and $12.10 for PPSP. These close similarities existed for all but total payments, number of physicians, and number of scheduled drugs. In each of these categories, the PPSP average was substantially lower than the control average. This suggests the PPSP sample was out-performing the control sample only in these three categories and not in all categories as is suggested by the before-and-after data for PPSP solely. In other words, if the pre-post comparison is ignored, the difference in performance between the PPSP and control sample was not very dramatic. But what about ignoring the pre-post comparison?

By and large, the pre-PPSP data show that the PPSP sample consisted of higher users in most categories. This implies that the control group was not like the PPSP group and therefore failed to provide a good basis for comparisons designed to gauge PPSP performance. If the PPSP sample was composed of abnormally higher users, then pre-post comparisons exaggerate the magnitude of change

that could be expected from PPSP enrollees with more normal pre-period utilization patterns. The opposite would be true if the control group was composed of abnormally low users.

The MSA was appropriately cautious in reporting the monitoring data on utilization and cost under PPSP because of the small random samples of PPSP enrollees and fee-for-service (FFS) recipients. The data probably greatly misindicate the type and level of change that would occur if a full and complete actuarial accounting of the entire PPSP and FFS populations was performed and analyzed. This is so because the PPSP sample seems to have had exceptionally high levels of use in the before period. This exaggerates savings that more normal users would have generated. Of course, this does not mean that PPSP is not or cannot produce significant change; it means simply that the question of PPSP effects remains largely unanswered from these data alone.

With these technical considerations in mind, it is still interesting to consider the MSA monitoring findings -- from the perspective of what they might be indicating. Subsequent evaluation should, for example, be able to explain how accurately or inaccurately the monitoring data represent PPSP performance. States need inexpensive, usually small-scale, monitoring approaches, particularly for such a complex initiative as PPSP. Such cross-validation may aid the development of this type of monitoring capability.

Based on the figures from the small sample study, MDSS estimated a savings for Medicaid of almost $2 million (net) in 1984-85 as a result of PPSP.(159) The savings through case management alone (not through HMO enrollments) were estimated at $1.3 million. This amounts to about $13.51 per enrollee year. The extra expenses and expected savings attributable to PPSP were estimated as follows:

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159. "Cost Benefit Analysis -- Physician Primary Sponsor Plan: Cost Projection for Fiscal Year 1984-85," draft MDSS document, September 10, 1984.

A. Expenses	
1. Case Management fee paid to physicians	$3,380,538
2. Administration	748,470
3. Elimination of pharmacy co-pay	1,017,318
Total Expenses	$5,146,326
B. Savings achieved by PPSP	
1. Decrease in utilization of medical services by recipients enrolled in PPSP	$6,414,648
2. Increase in HMO enrollment attributable to PPSP	723,146
Total Savings	$7,137,794
Total Net Savings from PPSP	$1,991,468

The gross savings expected through decreased utilization by PPSP enrollees (B.1 above) include savings in six specific service areas:

Physician payments	$3,256,452
Pharmacy	489,595
Laboratory services	956,541
Radiology services	377,478
Inpatient hospital	1,131,758
Outpatient hospital	202,824
Total	$6,414,648

Each of these figures was calculated by multiplying the projected 1,126,846 PPSP enrollee months for FY 1984-1985 times the estimated dollar savings per month through PPSP. For example:

Physician payments declined by 44.6 percent for the PPSP group and 21.5 percent for the control group. MDSS has assumed a 20 percent decline

in utilization of physician services by the PPSP group. The control group quarterly average is $43.34, or $14.45 per month. 20% of 14.45 is 2.89. $2.89 x 1,126,800 = $3,256,452.(160)

The only exception to this estimation method occurred with respect to inpatient hospital services. Given the extremely poor reliability of data from the small samples, MDSS analysts used a modest savings of five percent of the costs for the FFS control sample ($1.86 per month) times 1,126,800 enrollee months times 0.54 (adjustment for possible increases in inpatient per diem).

On the one hand, these estimates may have overstated the savings from PPSP. As noted, there were serious methodological problems with the techniques used to make the estimates, and these figures may simply have been incorrect. Even if these data were correct, the overall Medicaid expenditures may not have been declining as expected. Sponsor physicians conceivably could have shifted costs from PPSP recipients to non-PPSP recipients and continued to provide the same services as before. This is especially possible since almost all sponsor caseloads included both PPSP and non-PPSP recipients (see Chapter 3).

On the other hand, however, these data may actually have underestimated the savings attributable to a PCCM program. For example, Michigan also employs a separate lock-in program which ties the highest-utilizing recipients to an assigned sponsor. Given that these highest utilizers show the greatest reductions in utilization and expenditures, the PPSP can only show savings for the next-highest utilizing recipients. In a state without a separate lock-in program, the large savings achieved by restricting the highest utilizers would appropriately be attributed to PCCM.

Secondly, HMO enrollment increased with the introduction of PPSP into the marketplace. Exhibit 6.2 illustrates the trend in HMO enrollment from April, 1981, through December, 1983. The data are divided into three time periods:

(1) Enrollment for Wayne and surrounding counties prior to the introduction of PPSP (April, 1981 - February, 1982);

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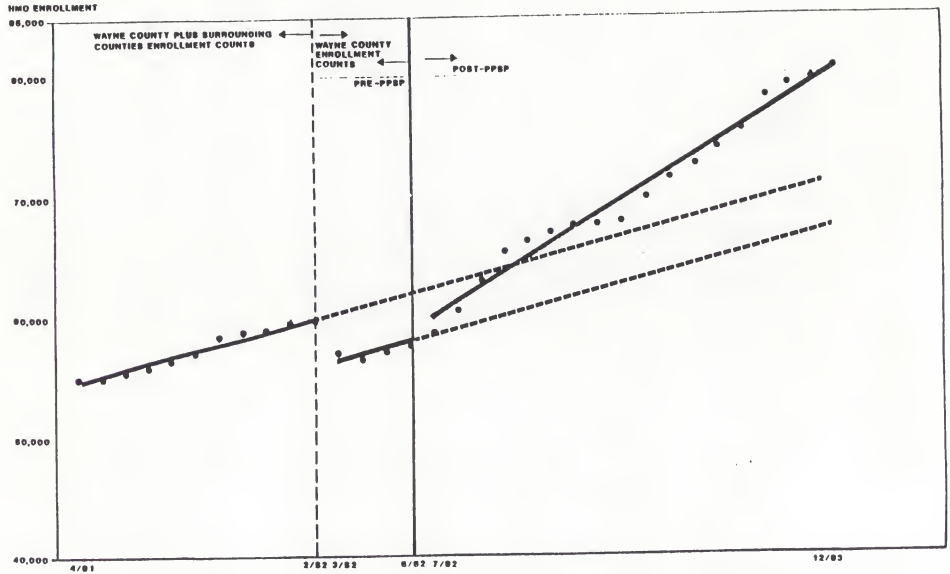
160. Ibid.

Exhibit 6.2

HMO ENROLLMENT FIGURES APRIL, 1981 THROUGH DECEMBER, 1983



Source: "Cost Benefit Analysis--PPSP: Cost Projection for Fiscal Year 1984-85," (MDSS document, no author), September 10, 1984.

(2) Enrollment for Wayne County prior to the introduction of PPSP (March, 1982 - June, 1982); and

(3) Enrollment for Wayne County after the introduction of PPSP (July, 1982 - December, 1983).

The line representing Wayne County enrollment after the introduction of PPSP shows a faster growth rate than enrollment prior to PPSP. (In December, 1983, approximately 80,500 Wayne County recipients were enrolled in HMOs). This is attributable to (1) greater promotion efforts by HMOs to compete with the PPSP and (2) county offices' promotion of PPSP and alternative medical services available to recipients.

Calculating that 8,941 of these HMO enrollees are attributable to PPSP, Michigan estimated a $723,146 savings for FY 1984-85. This results from a ten percent savings ($6.74) per month for each of the 8,941 HMO enrollees ($6.74 x 12 months x 8,941).

B. Three-Year Evaluation(161)

Under a special grant from HCFA to evaluate PPSP impact, the MDSS assessed utilization and cost effects through a pretest-posttest control group experiment. PPSP eligibles who had been continuously eligible for Medicaid for 12 months prior to sampling and then for 12 months after the experiment began were randomly assigned to either PPSP or the standard fee-for-service (FFS) program. Differences between the two groups in utilization and Medicaid costs during both the baseline 12 months and the 12 months after assignment were then calculated.

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161. This section is based on information acquired very recently from Michigan's Department of Social Services. While the bulk of this report is based on data collected during 1983 and 1984, we felt the recent information on savings was too important to exclude for the mere sake of consistency. A full report of the three-year evaluation can be found in the following document: R. Douglas Kosinski, Randy Knapp, Karen J. Carty, and Rose Ann Ward, The Impact of the Physician Primary Sponsor Plan on the Medicaid Program in Michigan, Planning and Evaluation Division, Office of Planning, Budget and Evaluation, Michigan Department of Social Services, September, 1986.

The initial random assignment in mid-1983 yielded PPSP and FFS groups of comparable size, history, utilization, etc. Delays in getting the experiment started, however, and high attrition of PPSP enrollees back into FFS (and out of the experiment) during the 12-month experimental period (from early 1984 to early 1985) resulted in unequal sample sizes and questionable comparability. Recipients in the PPSP sample who returned to FFS during the study period were found to be significantly more likely to be high level users of presecription drugs and lab tests and had substantially higher average total payments during the baseline period than those who remained in the PPSP. Additional analysis of these recipients' post-dropout utilization indicates, however, that they did not leave PPSP in order to secure high cost care. It is believed that, since many of the PPSP dropouts were higher than average users of services, the PPSP might have registered even more dramatic results had they stayed in the study sample.

In all, there were 3065 PPSP enrollees and 5212 FFS recipients in the final analysis of pre-post utilization and costs. PPSP and FFS comparisons were also made on the basis of pre-experimental service use levels (no, medium and high use of doctor visits), and type of eligibility (all AFDC, AFDC aged 0-14, AFDC aged 15-21, AFDC aged 22 and over, and all SSI). Data on the utilization and cost of health care services were obtained from Medicaid paid claim records, which included detailed information for each discrete service received by each recipient.

The findings from this three-year evaluation should be treated with caution because of possible undetected non-comparability in the PPSP and FFS samples and because the study only included recipients who were continuously eligible for Medicaid during the twelve months prior to and twelve months after PPSP enrollment. Non-continuously eligible recipients comprise a large proportion of the Medicaid population at any given time, and their exclusion from the analysis represents a major reason for concern. (Kansas, for example, estimated that excluding the non-continuous eligibles eliminated 75-80 percent of the PCCM recipients from the analysis).

Major Findings. Michigan's detailed evaluation showed that both overall and for most sub-groups, PPSP made a substantial difference in utilization and

costs during the twelve months after enrollment in early 1984. (These results are presented in Exhibits 6.3, 6.4 and 6.5.) Several more detailed tables are presented in Attachment 6.2.) Overall, PPSP was responsible for a 14.3 percent net reduction in utilization and a 9.1 percent net reduction in Medicaid costs. In effect, PPSP saved $147.25 per recipient per year in gross Medicaid service costs, and $104.26 after special administrative costs and care management fees are accounted for.

The monitoring study described in the previous section reported PPSP case management savings of $13.51 per enrollee year for 1984-85. The $104.26 savings reported here exceeds that estimate by $90.75, or 672 percent! Given the nature of the two studies, we suggest that the estimates from the large evaluation study are the more credible.

There is competing evidence to suggest that the savings reported above are both underestimates and overestimates for the entire PPSP population in 1984, but Michigan officials were fairly confident in the figures' accuracy. Assuming they are fair estimates, we calculated the likely savings for all PPSP enrollees. Using PPSP enrollment figures, we estimated that there were approximately 46,1000 enrollee years during 1984. At $104.26 savings per enrollee year, PPSP savings would amount to $4,806,386. This does not include any additional savings from PPSP's having directed some recipients into the HMO and CAP options.

Medicaid Subgroup Differences. While it appears that, overall, PPSP saved a good deal of money in 1984, there were differences, some of them substantial, among Medicaid subgroups. As shown in Exhibit 6.3, PPSP saved $155 per enrollee per year for ADC recipients, but cost $52 more for SSI recipients. Within ADC, PPSP saved almost twice as much among adults as among those aged 15-21; and it cost considerably more among children aged 0-14. The utilization data in Exhibit 6.4 indicate that, as we would expect, ADC children actually received more services -- overall and in each specific area except emergency room -- than their FFS counterparts. The largest differences occurred in inpatient hospital days and x-ray services. SSI recipients, however, received fewer services, ex-

EXHIBIT 6.3
PPSP SAVINGS (OVER FFS) ON TOTAL MEDICAID COSTS: 1983 TO 1984

ENROLLEE GROUP	1983 BASE FFS COSTS PER YEAR/ PERSON	GROSS PPSP EFFECT PER YEAR/ PERSON(1)	NET PPSP EFFECT PER YEAR/ PERSON(2)	PPSP EFFECT AS % OF BASE YEAR FFS COSTS
ALL MEDICAID	$1,147.71	- $147.25	- $104.26	- 9.1%
ALL AFDC	$947.81	- $197.82	- $154.83	- 16.3%
0-14	$349.80	+ $62.96	+ $105.95	+ 30.3%
15-21	$1,027.59	- $284.54	- $241.55	- 23.5%
22 +	$1,718.33	- $506.21	- $463.22	- 27.0%
ALL SSI	$2,077.65	+ $8.97	+ $51.96	+ 2.5%

SOURCE: TABLES DATED 10/30/86, RECEIVED FROM VERNON K. SMITH, DIRECTOR, BUREAU OF PROGRAM POLICY, MEDICAID SERVICES ADMINISTRATION, NOVEMBER 3, 1986.

(1) NEGATIVE FIGURES INDICATE THAT PPSP ENROLLEES HAD A GREATER REDUCTION OR A SMALLER INCREASE IN COSTS OVER TIME THAN DID THEIR FFS COUNTERPARTS. FIGURES ARE ESSENTIALLY THE RESULT OF DOUBLE DIFFERENCES: (PPSP 1984 - PPSP 1983) - (FFS 1984 - FFS 1983).

(2) GROSS EFFECTS PLUS $42.99, THE AVERAGE COST OF CASE MANAGEMENT FEES AND PPSP-SPECIFIC ADMINISTRATIVE COSTS FOR THE YEAR.

EXHIBIT 6.4
PPSP EFFECTS ON MEDICAID UTILIZATION: 1983 TO 1984

	PPSP EFFECT (PER YEAR/PERSON) AS % OF BASE YEAR (1983) (1)								
ENROLLEE GROUP	TOTAL NUMBER OF SERVICES	NUMBER OF INPATIENT HOPSITAL DAYS	NUMBER OF AMBULATORY SERVICES	NUMBER OF DOCTOR VISIT SERVICES	NUMBER OF EMERGENCY ROOM VISITS	NUMBER OF PRESCRIP-TIONS	NUMBER OF X-RAY SERVICES	NUMBER OF LAB TEST SERVICES
ALL MEDICAID	- 14.3%	- 8.3%	- 12.6%	- 15.9%	- 11.0%	- 11.1%	- 3.5%	- 28.3%
ALL AFDC	- 16.8%	- 11.7%	- 17.7%	- 18.7%	- 10.0%	- 16.6%	- 14.5%	- 30.6%
0-14	+ 8.1%	- 35.2%	+ 6.6%	+ 1.4%	- 8.0%	+ 7.1%	+ 19.6%	+ 7.9%
15-21	- 14.0%	- 3.2%	+ 13.5%	- 11.0%	- 2.2%	- 1.5%	- 11.2%	- 23.1%
22 +	- 26.2%	- 24.6%	- 27.0%	- 32.2%	- 17.1%	- 24.0%	- 24.4%	- 56.6%
ALL SSI	- 3.3%	- 3.9%	- 3.1%	- 9.7%	- 14.5%	- 9.0%	- 13.8%	- 18.8%

SOURCE: TABLES DATED 10/30/86, RECEIVED FROM VERNON K. SMITH, DIRECTOR, BUREAU OF PROGRAM POLICY, MEDICAID SERVICES ADMINISTRATION, NOVEMBER 3, 1986.

(1) NEGATIVE FIGURES INDICATE THAT PPSP ENROLLEES HAD A GREATER REDUCTION OR A SMALLER INCREASE IN UTILIZATION OVER TIME THAN DID THEIR FFS COUNTERPARTS. FIGURES ARE ESSENTIALLY THE RESULT OF DOUBLE DIFFERENCES DIVIDED BY AMOUNT OF FFS UTILIZATION DURING THE PRE-PPPS YEAR: [(PPSP 1984 - PPSP 1983) - (FFS 1984 - FFS 1983)] DIVIDED BY FFS 1983.

EXHIBIT 6.5
PPSP SAVINGS (OVER FFS) ON COSTS FOR SPECIFIC MEDICAID SERVICES: 1983 TO 1984(1)

ENROLLEE GROUP	INPATIENT HOSPITAL	TOTAL AMBULATORY	DOCTOR VISITS	LAB TESTS	X-RAYS	PRESCRIP-TIONS
ALL MEDICAID	- $70.93	- $76.36	-$14.73	-$10.82	- $3.31	- $9.00
ALL AFDC	- $104.94	- $92.87	-$16.27	-$17.49	- $5.24	- $12.01
0-14	+ $77.21	- $14.23	+ $2.09	+ $3.15	+ $2.84	+ $3.69
15-21	- $177.58	- $138.77	+ $5.89	-$14.18	- $8.24	+ $6.56
22 +	- $323.59	- $182.62	-$46.96	-$50.57	-$15.00	- $31.68
ALL SSI	+ $40.05	- $31.09	- $9.38	-$15.21	+ $4.03	- $22.44

(1) NEGATIVE FIGURES INDICATE THAT PPSP ENROLLEES HAD A GREATER REDUCTION OR A SMALLER INCREASE IN COSTS OVER TIME THAN DID THEIR FFS COUNTERPARTS. FIGURES ARE ESSENTIALLY THE RESULT OF DOUBLE DIFFERENCES: (PPSP 1984 - PPSP 1983) - (FFS 1984 - FFS 1983).

cept for x-rays. This suggests that SSI PPSP enrollees received some different, more expensive, services from those received by FFS SSI recipients. This is particularly likely for inpatient hospital services, which cost more for PPSP enrollees than for FFS, in spite of the fact that PPSP enrollees had fewer inpatient hospital days.

The fact that SSI enrollees and 0-14 ADC enrollees' expenditures were higher under PPSP does not necessarily mean that they should not have been in PPSP. It could mean that these groups received more thorough, more appropriate care under case management than they would have received without it. It could mean that PPSP is having the beneficial effect of redistributing some Medicaid services in favor of those who heretofore had been receiving less care than they needed.

A close look at the data for the ADC children (aged 0-14), for example, might be instructive here. In Exhibit 6.4, the data show that, under PPSP, ADC children received more services in every major category of ambulatory services, except emergency room (ER). Exhibit 6.5 shows that, even though overall expenditures were higher under PPSP, they were actually lower for total ambulatory services. Data on emergency room expenditures were unavailable, but it looks very much like the savings due to the sizeable reduction in ER -- which would be expected under case management -- more than offset the extra costs due to increases in other ambulatory services. Had there also been an increase in ER services under PPSP, we might be less inclined to view the overall increase under PPSP as a positive outcome. (It appears that savings due to reductions in ER use helped offset increases in other ambulatory services for the 15-21 year-old ADC enrollees, as well.)

Utilization Subgroup Differences. Michigan's evaluation provided some convincing evidence that the PPSP was reducing utilization (and expenditures) more among enrollees who had used relatively more services than others prior to implementation. Exhibit 6.6 shows how PPSP enrollees with high, medium, and no use of physician services prior to PPSP fared as compared to similar FFS recipients in terms of pre-PPSP to post-PPSP changes in service utilization and

EXHIBIT 6.6
PPSP UTILIZATION AND COST OUTCOMES
PRE-PROGRAM UTILIZATION LEVEL (1)

SERVICE	NON-USERS	MEDIUM USERS	HIGH USERS
INPATIENT HOSPITAL	0.15 AND 0.03 GREATER INCREASES IN OAYS AND STAYS, AND A $54 GREATER DECREASE IN COSTS.	0.12 AND EQUAL OECREASES IN OAYS AND STAYS, AND $53 OIFFERENCE BETWEEN THE PPSP OECREASE AND THE FFS INCREASE IN COSTS.	1.19, 0.15, AND $424 GREATER OECREASES IN OAYS, STAYS, AND COSTS.
EMERGENCY ROOM	0.01 SMALLER INCREASE IN UNITS OF USE.	0.13 GREATER DECREASE IN UNITS OF USE.	0.24 GREATER DECREASE IN UNITS OF USE.
DOCTOR VISITS	0.11 AND $2 SMALLER INCREASES IN VISITS AND COSTS.	0.71 AND $12 OIFFERENCES BETWEEN PPSP OECREASE AND FFS INCREASE IN VISITS AND COSTS.	8.77 AND $111 OECREASES IN VISITS AND COSTS.
LAB TESTS	0.02 AND $.47 GREATER INCREASES IN TESTS AND COSTS.	2.04 AND $17 INCREASES IN TESTS AND COSTS.	10.43 AND $90 GREATER OECREASES IN TESTS AND COSTS.
X-RAYS	0.10 AND $.72 GREATER INCREASES IN X-RAYS AND COSTS.	0.03 GREATER DECREASE IN X-RAYS, AND $3 OIFFERENCE BETWEEN PPSP OECREASE AND FFS INCREASE IN COSTS.	1.27 AND $24 GREATER OECREASES IN X-RAYS AND COSTS.
PRESCRIPTIONS	0.15 AND $1 GREATER INCREASES IN PRESCRIPTIONS AND COSTS.	1.18 OIFFERENCE BETWEEN PPSP OECREASE AND FFS INCREASE IN PRESCRIPTIONS AND $9 SMALLER INCREASE IN COSTS.	9.81 OIFFERENCE BETWEEN PPSP OECREASE AND FFS INCREASE IN PRESCRIPTIONS, $58 GREATER DECREASE IN COSTS.
TOTAL AMBULATORY SERVICES	0.40 SMALLER INCREASE IN UTILIZATION AND $69 GREATER INCREASE IN COSTS.	3.92 AND $96 OIFFERENCES BETWEEN PPSP OECREASE AND FFS INCREASE IN UTILIZATION AND COSTS.	42.39 AND $333 GREATER OECREASES IN UTILIZATION AND COSTS.
TOTAL MEDICAID PAYMENTS	0.30 SMALLER INCREASE IN NUMBER OF INVOICE LINES AND $18 GREATER INCREASE IN COSTS.	4.10 AND $149 OIFFERENCES BETWEEN PPSP OECREASE AND FFS INCREASE IN INVOICE LINES AND COSTS.	44.71 AND $758 GREATER OECREASE IN INVOICE LINES AND COSTS.

(1) OATA REPRESENT THE OIFFERENCE BETWEEN PPSP ENROLLEES AND FFS RECIPIENTS, IN TERMS OF EACH GROUP'S PRE (1983) AND POST (1984) PPSP CHANGE IN UTILIZATION/COST. IN THE STUDY POPULATION OF 126,703, FROM WHOM THE SAMPLES OF 3065 PPSP ENROLLEES AND 5212 FFS RECIPIENTS WERE ORAWN, 18.8% WERE LABELEO NON-USERS, 76.4% MEDIUM USERS AND 4.8% HIGH USERS, IN TERMS OF PRE-PPSP USE OF OOCTOR VISITS.

costs. As indicated in every row of Exhibit 6.6, PPSP had a much more dramatic impact on high service users than on medium or non-users. For example, while the program saved $758 per enrollee among prior high users, it saved only $149 per enrollee among medium users and actually cost $16 more per enrollee among non-users.

These findings are as expected, given the logic underlying case management. A major aim of PPSP was to reduce excessive, inappropriate utilization and improve access and care for those who had been receiving less than they should.(162)

Even though the overall savings per high service user were five times as great as those for medium users, the bulk of the total PPSP savings to Medicaid still came from the medium-user group. This is so because medium users outnumbered high users in the Medicaid population by almost 16 to 1. The evaluation samples were drawn from a population of 126,703 continuously eligible recipients, of whom 18.8 percent had not used any physician services during the year prior to the beginning of the study year in early 1984; 76.4 percent had used from 1 to 15 physician visits, and 4.8 percent had used over 15.

6.3 OBJECTIVE #2: INCREASE ACCESS TO MAINSTREAM CARE

From the recipients' point of view, the best advantage of PPSP may be the opportunity to establish a relationship with a primary care physician who will provide or refer most medical care. More recipients will have a single, identifiable physician rather than a patchwork of different physicians, clinics, and emergency facilities.

By September, 1984, about 54,000 of a targeted 286,000 Medicaid recipients in Wayne County had elected to enroll in PPSP. Although enrollment was far from complete, it represented a significant accomplishment, given the difficult cir-

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162. These findings were also consistent with those from an MSA study of high utilization physicians under PPSP. In a comparison of data for the third quarter of 1981 (pre-PPSP) and the third quarter of 1984 (post-PPSP), MSA found that: (1) total payments for the physicians had declined 32 percent from $1.8 million in 1981 to $1.3 million in 1984; (2) average payment per recipient declined 27 percent; and (3) average payments for lab tests declined 54 percent.

cumstances and uncharted terrain in Medicaid managed care being explored by Michigan. Nevertheless, an estimated 227,000, or 62 percent of all 368,000 recipients, continued to receive their medical care under the traditional fee-for-service system. If the FY 1984 twelve-month rate of PPSP growth continued (an average of about 2600 per month), only an additional 39,000 recipients would be enrolled by January, 1986, leaving the program 193,000 recipients, or 33 percent, short of its goal.

There are two simple reasons why many Medicaid recipients were not eager to join PPSP. First, there were few incentives for recipients voluntarily to give up their current flexibility to choose providers, hours, and location of service delivery. Michigan tried to address this problem in late 1983 by removing the co-payment on prescription drugs for PPSP participants, but this apparently was not enough incentive to join. The enrollment rate did not increase after the co-payment was eliminated.

Secondly, Medicaid recipients lost nothing by not joining PPSP. They were still allowed all previous services and options, and they could continue seeing their regular physician even if that physician had joined PPSP. Even if recipients joined PPSP, they could disenroll at any time and return to the traditional Medicaid program with no penalty. From a recipient's point of view, there were simply few good reasons to join PPSP.

Initially, the MSA struggled with low recipient response by implementing untried policies to require enrollment in PPSP. After nearly two years, the MSA adopted a less mandatory approach to ameliorate many of the complaints about the first approach. During the first months of the second, voluntary phase, the number of recipients enrolled in PPSP continued to increase at about the same rate as was achieved in the first phase. However, comparing the number of enrollments in May - August of the voluntary phase to the number in the same months during the previous year shows that 1,479 more enrollments, a nine percent increase, occurred during voluntary enrollment.

Of the three parties who might initiate or assist voluntary enrollment (the recipient, caseworker, or physician), the data are clear that physicians are the most effective at enrolling recipients. Notwithstanding some isolated com-

plaints of physicians pressuring their clients to join PPSP, this approach to recipient enrollment seems to have worked best. However, in late 1984, Michigan was in the midst of a comprehensive training program for caseworkers, and the state hoped that recipient contacts with caseworkers, either at initial eligibility determination or during redetermination, would become the main entry point into PPSP.

This training is clearly critical to the smooth functioning of PPSP, for there were several problems with the enrollment process at first. For example, information sent to recipients was sometimes confusing, misleading, or even inaccurate; the time given to select a physician sponsor was inadequate; and up to two-thirds of recipients could not be matched with the physician of their choice even after the recipient had enrolled in PPSP. Problems such as these discourage other recipients from joining PPSP and can encourage enrolled recipients to change sponsors or even to disenroll entirely.

As with the data on utilization and costs, there were two sources of data on access and satisfaction with care under PPSP, early monitoring surveys conducted by the Michigan League for Human Services (MLHS) and the three-year evaluation conducted by the Michigan Department of Social Services. Findings from each will be reviewed here.

A. Monitoring

From January, 1983, until December, 1984, an average of 61 percent of the enrollees responding to an MLHS monthly survey were generally satisfied with their medical care under PPSP. The monthly percentage of recipients who were satisfied under PPSP ranged from 42 to 81. Exhibit 6.7 provides details of the survey results. A crude comparison of these survey findings to the recipient enrollment methods shows that the percentage of enrollees satisfied with their medical care under PPSP did not change signficiantly during periods when different enrollment methods were used: 58 percent were satisfied during the early phase vs. 64 percent during the voluntary enrollment phase.

This is not to say, however, that there are no problems with medical care under PPSP. About one-quarter of the recipients surveyed in both 1983 and 1984

Exhibit 6.7

RECIPIENT SATISFACTION WITH MEDICAL CARE SINCE ENROLLING IN PPSP (APPROX. SIX WEEKS)

Jan. '83	58 (69%)	Jan. '84	16 (64%)
Feb. '83	56 (81%)	Feb. '84	10 (42%)
Mar. '83	24 (44%)	Mar. '84	9 (53%)
Apr. '83	22 (59%)	Apr. '84	10 (63%)
May '83	24 (56%)	May. '84	23 (74%)
June '83	21 (66%)	June. '84	15 (63%)
July '83	36 (68%)	July '84	18 (60%)
Aug. '83	15 (56%)	Aug. '84	25 (69%)
Sept. '83	13 (62%)	Sept. '84	31 (62%)
Oct. '83	8 (44%)	Oct. '84	34 (60%)
Nov. '83	16 (61%)	Nov. '84	26 (65%)
Dec. '83	8 (50%)	Dec. '84	30 (64%)

Monthly average of satisfied PPSP enrollees:

Mandatory Enrollment (Jan. '83 - Mar. '84) = 58.3%
Pend Status (Jan. '83 - Mar. '83) = 65%
Blind Assignment (Jan. '83 - May '83) = 62%
MSA Designation (July '83 - Mar. '84) = 56%
Computer Match (Apr. '83 - Mar. '84) = 57%

Voluntary Enrollment (Apr. '84 - Dec. '84) = 64%

Source: Michigan League for Human Services, Monitoring Project, telephone interview, February, 1985.

needed emergency room (ER) care and about six percent of those had difficulties obtaining care or were not served. Several problems emerged: the ER would not accept PPSP recipients; the ER threatened or actually billed the recipient because prior authorization was not secured (it is unclear as to why); the ER took a long time to contact the sponsor for prior authorization which meant the recipient had to wait in the ER waiting room (the sponsor and the Medicaid Sponsor Office were unreachable).(163)

During 1983 and 1984, about one-quarter of the surveyed recipients needed to contact their sponsor after normal office hours. Of these, about one-half knew the proper procedures and were successful in making contact with the sponsor. That is, the enrollees received instructions or they successfully contacted their sponsor. Of those who did not know where to telephone after normal business hours (35 percent in 1983, 22 percent in 1984), about a third waited for their sponsor's office to reopen and about two-thirds went to the emergency room for care. Fourteen percent in 1983 and 24 percent in 1984 knew how to reach their sponsor after hours but could not make contact. In 1983, this group was evenly split between going to the emergency room and waiting for the sponsor's office to reopen. In 1984, a higher percentage of recipients went to the emergency room instead of waiting for the sponsor's office to open. It is difficult to interpret these statistics because the enrollee's response may reflect varying degrees of medical urgency.

Of the third who responded that they had sought specialty care, about three-fourths were assisted and about 20 percent were not (the remainder did not respond to the question). Most enrollees who were not assisted commented on the sponsors' unfamiliarity with correct procedures or their unwillingness to help seek specialty care. Some enrollees noted that they were unaware of specialist availability or, while they were able to see a specialist, it was only after prolonged discussion with their sponsors. Additionally, there were problems when sponsor and recipient choice of a specialist differed. There were only small differences in the 1983 and 1984 responses about assistance obtaining specialty care. This might imply that the information supplied in 1984 to help

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163. See Attachment 6.2 "Survey of Medicaid Recipients in PPSP," for details.

providers and recipients understand the specialty care procedures did not clear up the misunderstandings completely.

B. Three-Year Evaluation

As part of the HCFA-sponsored evaluation of the PPSP, which was completed in September, 1986, MDSS conducted a pre-post survey of PPSP enrollees and FFS recipients' attitudes and perceptions regarding Medicaid service access and quality before and after the 1984 experimental period. Fifty-five percent of 5000 randomly selected PPSP enrollees and 57 percent of 5000 FFS recipients responded to a baseline questionnaire conducted in mid-1983. These respondents were sent a follow-up questionnaire one year later; 52 percent and 55 percent of the PPSP enrollees and FFS recipients, respectively, responded. In all, 1,428 PPSP enrollees and 1,560 FFS recipients answered both questionnaires.

The survey assessed perceptions of access to care in five areas: the convenience and ease with which recipients arrange to see a physician, the nature of the doctor visit itself, access to emergency care, referrals to specialists, and experience with second opinions. Satisfaction with care included seven dimensions: general satisfaction, and satisfaction with accessibility, the art of care, the technical quality of care, the outcomes of care, the physical environment, and the resources available.

Several of the survey findings are presented in Attachment 6.3. In general, the results indicated that PPSP had minimal positive or negative impact on either perceptions of access to care or client satisfaction with medical services. These results remained consistent even when the samples were broken down by level of pre-PPSP service use.

As for satisfaction, the only statistically significant difference between the pre-post changes in PPSP enrollees' and FFS recipients' attitudes was in the area of the technical quality of care. Satisfaction among PPSP enrollees dropped slightly more than did that of FFS recipients.

When the net satisfaction change results were broken out by pre-PPSP

utilization level, the results were surprising. MDSS had speculated that high users would be much more likely to show net decreases in satisfaction, since they were the group most affected by the PPSP program. The results did not bear out that speculation. The results for high users did not show substantially greater shifts than for the non-user and medium user groups, and no shift was of sufficient magnitude to have any clear implication of a meaningful change in client satisfaction levels.

A final aspect of the recipient survey was a series of questions directed at PPSP enrollees to measure the quality of information which they had had prior to choosing a sponsor and their general experience under the program. These questions yielded three particularly interesting findings:

(1) 82 percent of all enrollees responding indicated that they were still assigned to the physician with whom they had initially enrolled. This finding is consistent with results obtained by the MLHS Monitoring Project, and suggests that enrollees maintained stable physican relationships and did not engaged in "sponsor shopping". When enrollees did change physicians, the most commonly cited reasons were convenience of location and "other".

(2) Over 30 percent of the respondents indicated that they either did not have enough information about PPSP or they were not sure if they did. That the department's information effort was not entirely successful is borne out by the fact that over 38 percent thought they would lose Medicaid benefits if they failed to enroll in PPSP.

(3) Only 48 percent of the respondents were satisfied with the sponsor plan, and only 33 percent indicated a definite preference to stay in the program while 52 percent preferred the traditional FFS. These results are not surprising, since PPSP represented a considerable restriction in client freedom-of-choice.

6.4 OBJECTIVE #3: INCREASE PHYSICIAN PARTICIPATION IN THE MEDICAID PROGRAM

From the state's point of view, one of the main potential advantages of PPSP is the opportunity to convince more physicians to participate in the Medicaid program. Conventional wisdom in Medicaid is that more participating primary care physicians are needed in order to allow recipients a better chance to find and maintain a satisfactory doctor-patient relationship.

However, this logic may not hold strictly for Wayne County, Michigan. Even though other parts of the country (and, indeed, other parts of Michigan) suffer from too few Medicaid physicians, this problem is not great in Wayne County. Even before PPSP was devised, a substantial proportion of Wayne County physicians accepted Medicaid clients. Given the average Medicaid caseload, this participation rate is sufficient to serve the Medicaid recipients in Wayne County.

Accordingly, Michigan's main benefit from PPSP in Wayne County is the chance to manage the overall care being provided to Medicaid recipients, with a particular emphasis on the cost-effectiveness of that care. From the state's point of view, the first priority is to convince the existing Medicaid primary care physicians to join PPSP so that case management can be improved. Convincing new physicians to join the Medicaid program via PPSP is a secondary goal.

However, neither goal is being achieved at the rates originally predicted. By late 1984, only 1162 of the primary care-oriented physicians who were serving Medicaid recipients before PPSP had signed sponsor contracts. This represents only 37 percent of the main target group for PPSP physician recruitment. Put differently, 63 percent of Wayne County primary care-oriented physicians who served Medicaid recipients before PPSP are still serving them, but under the same system as before.

This would not be a problem if new physicians were joining Medicaid via PPSP and were accepting case management responsibilities. However, there is no evidence that new physicians, those who did not serve Medicaid before PPSP, have signed sponsor contracts in significant numbers. Apparently, PPSP has not led to expanded participation in Medicaid -- particularly for primary care physicians. Since there are no data on the number of Medicaid enrollees in the caseloads of non-PPSP primary care physicians, the meaning of their non-participation is still unclear. If a large proportion of these non-participants have comparatively large Medicaid caseloads, the meaning could be significant. For example, continuing non-participation could either hinder reaching PPSP objectives for enrolling Medicaid recipients or lead to the transfer of recipients from non-sponsor to sponsor physicians.

The reasons physicians are not joining PPSP seem to parallel the reasons recipients are not joining: lack of sufficient incentives to join and no effective penalties for not joining. The extra $3 case management fee and the opportunity to increase or insure a stable Medicaid caseload were intended as incentives to join, and these seem to have been effective to some degree. As Chapter 3 points out, physicians like these aspects of PPSP and view them as good reasons to join. However, many physicians apparently view the additional $3 as basically a long-overdue increase in the State's regular Medicaid reimbursement rate. Medicaid caseloads have not increased for those joining PPSP, and the faith in stable caseloads was shaken early by problems with recipient assignments (especially the troublesome blind assignments) and the 20 percent rate with which recipients are changing sponsors. Add these difficulties to the extra paperwork and additional contacts with State agencies, both of which are long-standing complaints physicians have voiced against Medicaid participation, and many physicians apparently see little advantage in joining PPSP.

To counteract this early reluctance to join, Michigan added a third incentive which may have been more effective. In the Fall of 1984, Michigan began to allow EPSDT services to be included in the scope of reimbursable PPSP care. Since that time, several physicians have joined PPSP, and at least some of the growth can be attributed to this new incentive.

From a physician's perspective, there also seem to be few penalties for not joining PPSP. As with recipients, physicians can continue just as before, treating whichever Medicaid recipients they like and being reimbursed under the traditional fee-for-service. The only theoretical disadvantage of not joining PPSP would occur if all Medicaid recipients were enrolled in the plan; under those circumstances, physicians would have to join PPSP to keep their Medicaid caseloads. However, since so few recipients have been enrolled, probably few physicians are seriously concerned by that possibility.

Because of these marketing handicaps, it is not surprising that few physicians have been recruited from the blanket appraoch tried at first. These marketing efforts are modestly successful. From February to November, 1983, the

MSA mailed 1523 marketing letters to targeted non-sponsor physicians in Wayne County. This effort resulted in 45 physicians (3.0 percent) signing sponsor contracts, approximately five or six each month. From April to August, 1984, the MSA mailed 385 marketing letters to targeted non-sponsor physicians. Eighty-four (21.8 percent) returned completed contracts, approximately 17 each month. While sending invitations and publicizing endorsements has no doubt convinced some physicians to join, more have been recruited by the special efforts made when one of a physician's Medicaid clients enrolls in the program.

The readily available information indicates that the typical physician with a sponsor contract is one who served Medicaid patients before PPSP and practices one of the six following specialties: general practice, family practice, internal medicine, obstetrics and gynecology, pediatrics, and general surgery. This group accounted for an estimated 91.5 percent of the 1270 physicians with sponsor contracts as of September, 1984.

6.5 OBJECTIVE #4: IMPROVE MANAGEMENT OF CARE TO RECIPIENTS

The final objective of Michigan's PPSP system is to manage care to Medicaid recipients better, particularly by insuring that sponsor physicians carefully direct services and expenditures for their clients. When developing PPSP in 1981, Michigan physicians argued that controlling patient services, not the dollars or reimbursement system, was the key to controlling Michigan's Medicaid expenditures. Objective #4 is the key to that argument, and success or failure on this objective will spell success or failure for the entire PPSP cost-containment effort.

While implementing PPSP, however, Michigan discovered a fine line between implementing policies to achieve cost-effective financial management and maintaining PPSP's appeal to physicians. The PPSP policies to achieve cost-effective financial management led to impediments with impacts ranging from suspended implementation of PPSP during litigation to time-consuming hearings for disgruntled physicians. Therefore, the MSA procedures to ensure compliance with cost-effective financial management have not been implemented in a way which would give justice to the weight of their original intention. Cost-

effective financial management remains one of the most elusive goals for PPSP.

The most obvious example of this elusiveness is the lack of any system for monitoring sponsor compliance with the "95th percentile rule" built into PPSP. According to this rule, sponsor physicians with average per-recipient expenditures above the 95th percentile for all sponsors would be subject to sanctions, including possible ejection from the Medicaid program. However, as noted in Chapter 4, Michigan has yet to design or implement a system to enforce this rule. Until that occurs, it is impossible to gauge its effectiveness.

Another problem involves verifying prior authorization. As we saw in Chapter 2, prior authorization for all services, whether provided by the sponsor or through referral to a specialist, is the primary way PPSP influences an individual recipient's utilization. However, it is difficult to determine when authorization was received, especially given the close relations between physicians and the legitimate need for occasional specialist or emergency care. Without ways to insure that approval was actually received before services were delivered, the prior authorization rule is simply a bureaucratic exercise in checking for a proper signature on the proper line.

Given the state of these monitoring systems, it is not surprising that, as of late 1984, not a single physician sponsor had been sanctioned for failing to provide cost-effective care. This is in spite of the fact that the state's warning signal of recipient overutilization, the number of FM-140s sent to sponsors each month, was fairly high and seemed to be rising. This bodes ill for PPSP's success on this objective, and this trend needs to be reversed quickly.

There are some data on the possible impact of the PPSP on the practice patterns of physicians. The PPSP unit of the MSA recently completed a study of 54 physicians who had been identified as high cost and high utilization providers prior to their enrollment in PPSP.(164) These physicians had been designated as "provisional" or had been sent "on-notice" letters for having exceeded the criteria outlined in Addendum A of the PPSP contract (See Attachment 1.2). In

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164. "Physician Primary Sponsor Plan: Provisional Provider Comparison," no date.

the study described here data on these physicians' services and payments for the third quarter of 1981 (pre-PPSP) and for the third quarter of 1984 (post-PPSP) were compared. (Intially, there were 63 physicians in the study population, but 1981 data were unavailable for nine of them).

Between 1981 and 1984, there were significant declines in five cost-effectiveness criteria: total payments (32%) average payments per recipient (27%), average payments per office service (8%), average pathology payments (54%), and precentage of recipients with pathology (17%).

There was a five percent increase in the number of Medicaid recipients seen by these physicians (from 18,065 in 1981 to 18,909 in 1984). If this increase is taken into account, then the decline in total payments is 35 percent instead of 32.

The data suggest that PPSP had an impact on the practice patterns of these 54 pre-PPSP high-use physicians, but they are not conclusive by any means. Without a control group of similar non-PPSP physicians, it cannot be determined whether PPSP indeed was the source of the change. Other factors were likely involved, too. For example, in early 1982, just before PPSP implementation, the MSA gave a list of physicians with high billings for laboratory services to the state medical societies. The societies then counseled these physicians regarding their practice patterns.

Another possible factor is the reporting mechanism. The data used in the study are only for lab work done in the physician's office. Some of the large decline in pathology payments could be due to a shift by these physicians from lab work done in the office to lab work done by external laboratories, which bill Medicaid separately.

While it is likely that other factors were involved in the pre-post-PPSP changes among these high use physicians, the PPSP unit staff were confident that the program played a large role. In their report, they wrote:

> Still the dramatic decline observed cannot be attributed solely to these factors. The PPSP contract process involved notification to

sponsor physicians of their standing in terms of cost and utilization in comparison to their class group averages. For many, this was the first notification. The contract also notified the physician that his/her utilization would be monitored on an ongoing basis. It is apparent from the findings that PPSP is having a positive effect upon the costs and practice patterns of the physicians participating in the program.(165)

6.6 CONCLUSIONS

Perhaps the most important conclusion to draw from this case study is that Michigan's original goals for PPSP were very ambitious, no doubt too ambitious. The objectives for physician recruitment and recipient enrollment were not met, in large part, because the original schedule was unrealistic, given the state's past experience with case management in Medicaid and the resources allocated to the task. This led to the use of untested approaches, such as strict mandatory enrollment, which were not as effective as expected, had to be canceled, and slowed other aspects of implementation.

Another conclusion is that, from an evaluation perspective, the PPSP objectives are not well-defined except in the important area of cost-containment. For example, the cost-containment objective is specified in measurable terms because a dollar estimate of the expected change in expenditures has been established. Also, there are details about how subcategories of expenditure will be affected. This does not mean that there are no problems with the way savings estimates were developed. However, in comparison to other objectives, the sequence and expected savings are well developed.

For the other objectives, there is less specification. The use of the terms "increase" or "decrease" (in comparison to pre-PPSP or a fee-for-service comparison group) is vague and introduces considerable ambiguity about what constitutes success. For example, there are gaps in the meaning of "increased primary physician participation." If the number of physicians decreases in some areas and increases in others, will the objective be accomplished if there is a net increase? What if the total increases but a lower percentage of areas have

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165. Ibid., p.3.

an appropriate ratio of physicians to recipients? These and other ambiguities signal the low level of definition (measurability) of the non-financial PPSP objectives. As the evaluation of PPSP continues, it will be important to further clarify the intent underlying the less well-specified objectives and further develop measurement and analysis accordingly.

A third conclusion is that other states implementing a PCCM system should narrow the scope of their initial efforts in order to introduce the system smoothly. After this smooth start, the state can then expand the program judiciously as it sees fit. There are at least three possible ways to narrow the initial scope. First, the system can be introduced into a well-defined geographic area. Michigan took this approach, but it may have erred by choosing Wayne County because of its large Medicaid population. While this decision certainly offered the best chance to reduce costs, a smaller county might have provided less pressure while perfecting the unique PPSP systems.

A second way to narrow early implementation is with carefully targeted physician recruitment efforts. Michigan began by attempting to recruit all physicians in Wayne County but eventually shifted to targeting those physicians requested by one of their clients. Even if other states attempt to recruit all physicians, they need to use different recruitment techniques for physicians who are currently participating in Medicaid than for those who are not. As for recipient enrollment, Michigan also found that simply sending a general brochure to all eligible recipients was not as effective as allowing sponsor physicians to facilitate enrollments.

A third way to narrow early implementation is to develop and maintain reasonable expectations about early progress. PCCM systems are a major change from the way Medicaid programs have been operating for many years. This case study indicates that the expected results from PPSP, like savings or improvements in the continuity of recipient care, cannot occur as quickly as was originally expected. In short, the potential benefits of an innovative service delivery plan like PPSP can be expected to accrue over several years instead of the few short months envisioned by PPSP planners and legislators and other officials eager to find programs to improve the management of Medicaid service utilization and expenditures.

Finally, the data currently available on Michigan's PPSP provide fairly reliable evidence that, in spite of all the problems with implementation, case management can save money for Medicaid. Further, it can do it without hurting access to and quality of care, at least as perceived by the recipients involved. While there are indications that case management in Michigan actually may have improved access and quality for certain recipient groups -- young children, for example -- it was not particularly well received and appreciated by half the recipients it affected.

6.7 A BRIEF UPDATE ON FUTURE PLANS FOR THE PPSP

As noted earlier, most of the data and findings in this report cover the first few years of PPSP planning and implementation, through September, 1984. This report covers very little of what has transpired between late 1984 and the present. The past two years have witnessed some progress and growth, but the PPSP is still evolving and will continue to do so for some time to come. It continues to receive intense scrutiny by MDSS officials and representatives of the provider and recipient communities. Future plans for case management include the following:

(1) Continued consideration of expanding the program to the entire state. No firm plans have been made, however. MDSS has decided to expand the Capitated Ambulatory Plan statewide.

(2) More targeting of high users for case management, including expansion of the lock-in program from 2,500 to 10,000 recipients statewide. The committee will continue to consider whether recipients who leave the lock-in program should be moved directly into the PPSP and whether other high users should be placed in the PPSP, CAP or HMO case management programs.

(3) Elimination of all co-payments for PPSP enrollees.

(4) Support for legislative funding for a single toll-free recipient hotline for information on all MDSS programs, including Medicaid and PPSP.

(5) Development of cost standards to screen out high service providers among potential PPSP sponsor physicians and to terminate the contracts of sponsors who provide excessive services after enrollment.

(6) Development of a risk pool arrangement for sponsors, that could involve rewarding cost-effective sponsors and penalizing those who are not cost-effective.

(7) Implementation of a pilot for mandatory PPSP/HMO enrollment of ADC clients in one section of Wayne County.

The provider community is resisting some of these plans, particularly those dealing with more targeting and creation of a sponsor risk pool. It is likely that, in the well-established PPSP tradition, a great deal of discussion and compromise will transpire before specific provisions are implemented.

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